

COPY

-Application

River Park

Hospital, LLC

CN1407-030



River Park Hospital

In partnership with Saint Thomas Health

**INITIATION OF GERIATRIC PSYCHIATRIC SERVICES
AT
RIVER PARK HOSPITAL**

**CERTIFICATE OF NEED APPLICATION
JULY 2014**

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SECTION A:

APPLICANT PROFILE

Please enter all Section A responses on this form. All questions must be answered. If an item does not apply, please indicate "N/A." **Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.**

For Section A, Item 1, Facility Name must be applicant facility's name and address must be the site of the proposed project.

For Section A, Item 3, Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence, if applicable, from the Tennessee Secretary of State.

For Section A, Item 4, Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in Tennessee Code Annotated, §68-11-1602 in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.

For Section A, Item 5, For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.

Please describe the management entity's experience in providing management services for the type of the facility, which is the same or similar to the applicant facility. Please describe the ownership structure of the management entity.

For Section A, Item 6, For applicants or applicant's parent company/owner that currently own the building/land for the project location; attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements must include anticipated purchase price. Lease/Option to Lease Agreements must include the actual/anticipated term of the agreement and actual/anticipated lease expense. The legal interests described herein must be valid on the date of the Agency's consideration of the certificate of need application.

JUL 16 10:02:28

1. <u>Name of Facility, Agency, or Institution</u>			
<u>River Park Hospital, LLC</u>			
Name			
<u>1559 Sparta Street</u>			
Street or Route		<u>Warren</u>	
		County	
<u>McMinnville</u>	<u>TN</u>	<u>37110</u>	
City	State	Zip Code	
2. <u>Contact Person Available for Responses to Questions</u>			
<u>Joseph Mazzo</u>		<u>Chief Operating Officer</u>	
Name		Title	
<u>River Park Hospital</u>		<u>Joseph.Mazzo@capellahealth.com</u>	
Company Name		email address	
<u>1559 Sparta Street</u>		<u>McMinnville</u>	<u>TN</u> <u>37110</u>
Street or Route		City	State Zip Code
		<u>931-815-4203</u>	<u>931-815-4710</u>
Association with Owner		Phone Number	Fax Number
3. <u>Owner of the Facility, Agency or Institution</u>			
<u>Capella Healthcare, Inc</u>		<u>615-764-3000</u>	
Name		Phone Number	
<u>501 Corporate Centre Drive</u>		<u>Williamson</u>	
Street or Route		County	
<u>Franklin</u>	<u>TN</u>	<u>37067</u>	
City	ST	Zip Code	
4. <u>Type of Ownership of Control (Check One)</u>			
A. Sole Proprietorship	_____	F. Governmental (State of TN or Political Subdivision)	_____
B. Partnership	_____	G. Joint Venture	_____
C. Limited Partnership	_____	H. Limited Liability Company	_____
D. Corporation (For Profit)	<u>X</u>	I. Other (Specify) _____	_____
E. Corporation (Not-for-Profit)	_____		

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

5. **Name of Management/Operating Entity (If Applicable)**

Name _____

Street or Route _____

County _____

City _____

ST _____

Zip Code _____

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. **Legal Interest in the Site of the Institution (Check One)**

- | | | | |
|-------------------------|----------|--------------------|-------|
| A. Ownership | <u>X</u> | D. Option to Lease | _____ |
| B. Option to Purchase | _____ | E. Other (Specify) | _____ |
| C. Lease of _____ Years | _____ | | |

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

7. **Type of Institution (Check as appropriate--more than one response may apply)**

- | | | | |
|--|----------|--|-------|
| A. Hospital (Specify) Acute Care | <u>X</u> | I. Nursing Home | _____ |
| B. Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty | _____ | J. Outpatient Diagnostic Center | _____ |
| C. ASTC, Single Specialty | _____ | K. Recuperation Center | _____ |
| D. Home Health Agency | _____ | L. Rehabilitation Facility | _____ |
| E. Hospice | _____ | M. Residential Hospice | _____ |
| F. Mental Health Hospital | _____ | N. Non-Residential Methadone Facility | _____ |
| G. Mental Health Residential Treatment Facility | _____ | O. Birthing Center | _____ |
| H. Mental Retardation Institutional Habilitation Facility (ICF/MR) | _____ | P. Other Outpatient Facility (Specify) | _____ |
| | | Q. Other (Specify) | _____ |

8. **Purpose of Review (Check as appropriate--more than one response may apply)**

- | | | | |
|---|----------|---|----------|
| A. New Institution | _____ | G. Change in Bed Complement | _____ |
| B. Replacement/Existing Facility | _____ | [Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation] | _____ |
| C. Modification/Existing Facility | <u>X</u> | | |
| D. Initiation of Significant Health Care Service as defined in TCA § 68-11-1607(4) (Specify) <u>Geri Psych Services</u> | <u>X</u> | | <u>X</u> |
| E. Discontinuance of OB Services | _____ | H. Change of Location | _____ |
| F. Acquisition of Equipment | _____ | I. Other (Specify) | _____ |

9. **Bed Complement Data**

Please indicate current and proposed distribution and certification of facility beds.

	<u>Current Beds</u>	<u>Staffed Beds</u>	<u>Beds Proposed</u>	<u>TOTAL Beds at Completion</u>
	<u>Licensed *CON</u>			
A. Medical				
B. Surgical (General Med/Surg)	<u>125</u>	<u>48</u>	<u>(10)</u>	<u>115</u>
C. Long-Term Care Hospital				
D. Obstetrical				
E. ICU/CCU				
F. Neonatal				
G. Pediatric				
H. Adult Psychiatric				
I. Geriatric Psychiatric		<u>10</u>	<u>10</u>	<u>10</u>
J. Child/Adolescent Psychiatric				
K. Rehabilitation				
L. Nursing Facility (non-Medicaid Certified)				
M. Nursing Facility Level 1 (Medicaid only)				
N. Nursing Facility Level 2 (Medicare only)				
O. Nursing Facility Level 2 (dually certified Medicaid/Medicare)				
P. ICF/MR				
Q. Adult Chemical Dependency				
R. Child and Adolescent Chemical Dependency				
S. Swing Beds				
T. Mental Health Residential Treatment				
U. Residential Hospice				
TOTAL	<u>125</u>	<u>58</u>		<u>125</u>
*CON-Beds approved but not yet in service				

10. Medicare Provider Number 044-0151

Certification Type Acute Care Hospital

11. Medicaid Provider Number 044-0151

Certification Type Acute Care Hospital

12. If this is a new facility, will certification be sought for Medicare and/or Medicaid? N/A

13. **Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area. Will this project involve the treatment of TennCare participants? Yes** If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or *plans to contract*.

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

RESPONSE: River Park Hospital (RPH) participates in the major TennCare MCOs serving patients in the area: Americhoice (out-of-network) and Amerigroup (in-network). In total, RPH participates in approximately 71 managed care organizations/behavioral health organizations. Please see **Attachment A,13 (Tab 6)** for a list of managed care contracts in which RPH participates.

NOTE: **Section B** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. **Section C** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

- I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

RESPONSE: Please see the following two pages for the executive summary.

INITIATION OF GERIATRIC PSYCHIATRIC SERVICES

PROJECT OVERVIEW: River Park Hospital (RPH), the applicant, was founded in 1970 in McMinnville (Warren County). The current facility was built in 1996 and has 125 beds in which it provides acute care services. With this project, RPH seeks to initiate a 10 bed geriatric psychiatric service. In order to contain costs and charges, RPH proposes to convert 10 existing medical-surgical beds to 10 geriatric psychiatric beds (for patients aged 55 and older), resulting in no increase in total licensed bed capacity.

OWNERSHIP STRUCTURE: River Park Hospital was purchased by newly-founded Capella Healthcare in November of 2005, along with Grand View Medical Center in Jasper and two other hospitals outside of Tennessee. Since then, Capella Healthcare has emerged as a national leader in the development and operation of healthcare facilities in non-urban markets. Capella has since acquired nine hospitals from Community Health Systems in February 2008, including White County Community Hospital in Sparta, as well as DeKalb Community Hospital in Smithville and Stones River Hospital in Woodbury in July 2011.

In May 2012, Capella Healthcare and Saint Thomas Health finalized a landmark partnership designed to improve healthcare throughout Middle Tennessee and Southern Kentucky. Based in Nashville, Saint Thomas Health includes five hospitals affiliated with Ascension Health Ministry, the nation's largest Catholic system and non-profit health system. The partnership resulted in the joint ownership and operation of Capella's four Middle Tennessee hospitals, including **River Park Hospital** in McMinnville, **Highlands Medical Center** (formerly White County Community Hospital) in Sparta, **DeKalb Community Hospital** in Smithville and **Stones River Hospital** in Woodbury, all in Tennessee. These hospitals operate as part of the Saint Thomas Health Network, which holds an equity interest. In addition, Saint Thomas Health is the tertiary care partner for the hospitals within the new venture. Capella is the managing member and the majority partner in the venture, and is the exclusive development partner for Saint Thomas Health across Middle Tennessee and Southern Kentucky.

SERVICE AREA: Based on historical patient origin data, RPH's service area for this project is comprised of 6 Tennessee counties – Coffee, DeKalb, Grundy, Van Buren, Warren, and White Counties. Together, these six counties accounted for over 96% of the total hospital inpatients at River Park Hospital. Within the service area, geriatric psychiatric inpatient services are presently provided at 60-bed Highlands Medical Center in Sparta (White County). Seventy-one-bed DeKalb Community Hospital in Smithville (DeKalb County) does not offer inpatient psychiatric services.

NEED: The specialized geriatric psychiatric beds in the six-county service area are well utilized. The 10 beds at Highlands Medical Center had an average daily census of 8.4 patients (83.8% occupancy).

With this Certificate of Need application, River Park Hospital seeks to initiate geriatric psychiatry services to meet the needs of service area patients.

This proposed 10 bed service arose out of the need demonstrated within the service area for geriatric psych services. As will be demonstrated in the need section of this application, the six-county service area will require an additional 10 beds by Year 2 (2016) of this proposed project.

This projected bed need is conservative, however. At the April 2014 HSDA CON meeting, representatives from both the Tennessee Department of Mental Health (Sandra Braber-Grove, Division of General Counsel) and the Division of Health Planning (Jeff Ockerman, Director-Division of Health Planning) both acknowledged that the current psychiatric bed need guidelines (30 beds/100,000 population) are inadequate.

If approved, River Park Hospital will make its geriatric psychiatric program available for both voluntary and involuntary admissions. This will help reduce inappropriate emergency department utilization and costs for all hospitals throughout the area, not just for Capella-affiliated facilities.

EXISTING RESOURCES: RPH does not currently offer any behavioral health services. The proposed project will not result in any services being terminated and will instead improve access to psychiatric patients that are medically compromised and/or geriatric.

PROJECT COST: The total estimated cost of the proposed project is \$1,199,250. Project costs include \$40,000 in equipment-related expenses and \$975,000 for renovations to the 5,066 square feet of existing space. The cost per square foot, \$192.46, is comparable to other Tennessee psychiatric bed addition projects and is discussed in further detail later in the application.

FUNDING: The project will be funded through unrestricted cash reserves of River Park Hospital.

FINANCIAL FEASIBILITY: The proposed completion date of the entire project is April 2015. Projections for Years 1 and 2 indicate that the project is financially feasible.

STAFFING: This project requires only minor increases in staffing. Due to an anticipated increase in the volume of patients served in the 10 converted beds, this project will require a 6.3 FTE increase in registered nurses. By shifting manpower within departments, RPH can fill this FTE requirement internally using existing staffing.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

- A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of \$5 million) and other facility projects (construction cost in excess of \$2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

RESPONSE: Although the construction costs for this hospital project are well below the \$5 million threshold, the applicant has included the completed Square Footage Exhibit the following page. There is no new construction planned. Instead, this project proposes the renovation of 5,066 square feet of existing hospital space at a cost of \$192.46 per square foot, and will create a 10 bed geriatric psychiatry unit. Affected areas will include 6 former patient rooms located on the third floor which are currently held for overflow patients. This project proposes to renovate these rooms for reuse as patient rooms.

- B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

RESPONSE: This project proposes the conversion of 10 of the hospital's currently licensed general medical/surgical beds to psychiatric beds. This proposed conversion of beds will provide geriatric psychiatric patients with greater access to local services not available elsewhere in the service area. The project will not result in any additional beds at the hospital.

Square Footage Exhibit

[illegible]

- C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. **Adult Psychiatric Services**
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds

RESPONSE: The scope of this project involves the conversion of 10 existing general medical/surgical beds to geriatric psychiatric beds. No other service-specific rules are applicable to this project.

As discussed more fully in the need section of this application, the proposed conversion of the 10 beds arose out of the need demonstrated by the actual geriatric psych utilization within the service area.

- D. Describe the need to change location or replace an existing facility.

RESPONSE: Not applicable. This project does not propose a change in location, or the replacement of an existing facility.

- E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of \$1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):

- a. Describe the new equipment, including:
 1. Total cost; (As defined by Agency Rule).
 2. Expected useful life;
 3. List of clinical applications to be provided; and
 4. Documentation of FDA approval.
- b. Provide current and proposed schedules of operations.

RESPONSE: Not applicable. This project does not propose the purchase of any fixed-site

major medical equipment

2. For mobile major medical equipment:

- a. List all sites that will be served;
- b. Provide current and/or proposed schedule of operations;
- c. Provide the lease or contract cost.
- d. Provide the fair market value of the equipment; and
- e. List the owner for the equipment.

RESPONSE: Not applicable. This project does not propose the purchase of any mobile major medical equipment

3. Indicate applicant's legal interest in equipment (i.e., purchase, lease, etc.). In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

RESPONSE: Not applicable. This project does not involve the purchase of major medical equipment.

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which **must** include:

1. Size of site (*in acres*);
2. Location of structure on the site; and
3. Location of the proposed construction.
4. Names of streets, roads or highway that cross or border the site.

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

RESPONSE: Please see Attachment B, III.(A) (Tab 7) that depicts the 14.4-acre site.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

RESPONSE: This project proposes the renovation of existing space within River Park Hospital. The hospital is conveniently located in McMinnville on Sparta Street near its intersection with U.S. 70S/State Route 1, both major thoroughfares through the city. The city of McMinnville does not offer public transportation services

Please see Attachment B, III.(B).1 (Tab 8) for a map depicting the service area and the thoroughfares that connect each county to the proposed site.

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of

white paper.

NOTE: **DO NOT SUBMIT BLUEPRINTS**. Simple line drawings should be submitted and need not be drawn to scale.

RESPONSE: Please see Attachment B, IV (Tab 9) for the floor plan schematics.

V. For a Home Health Agency or Hospice, identify:

1. Existing service area by County;
2. Proposed service area by County;
3. A parent or primary service provider;
4. Existing branches; and
5. Proposed branches.

RESPONSE: Not applicable. The project does not involve a Home Health Agency or Hospice.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. Please type each question and its response on an 8 1/2" x 11" white paper. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.
 - a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

RESPONSE: Included below are the Criteria and Standards required for the Construction, Renovation, Expansion, and Replacement of Health Care Institutions and Psychiatric Inpatient Services.

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

RESPONSE: Acknowledged. Please see the Criteria and Standards required for Psychiatric Inpatient Services discussed in the section above.

2. For relocation or replacement of an existing licensed health care institution:

- a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

RESPONSE: Not applicable.

- b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

RESPONSE: Not applicable.

3. For renovation or expansions of an existing licensed health care institution:

- a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

RESPONSE: As demonstrated in the need section of this application, RPH's project will serve an unmet need for geriatric psych services.

- b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

RESPONSE: As demonstrated in the need section of this application, RPH's project will serve an unmet need for geriatric psych services.

PSYCHIATRIC INPATIENT SERVICES

A. Need

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in Joint Annual Reports).

RESPONSE: The state need projections for psychiatric inpatient services of 30 beds per 100,000 *general* population do not adequately reflect the need for geriatric psychiatric services in the proposed service area. As with general acute care beds, elderly patients utilize inpatient psychiatric services at a much higher rate than the general population. At the April 2014 HSDA CON meeting, representatives from both the Tennessee Department of Mental Health (Sandra Braber-Grove, Division of General Counsel) and the Division of Health Planning (Jeff Ockerman, Director-Division of Health Planning) both acknowledged that the current psychiatric bed need guidelines (30 beds/100,000 population) are inadequate.

As such, age-adjusted bed need projections show a much greater need for additional geriatric psychiatric beds in the service area. Additionally, when running the bed need projections for the six-county service area for 2012, the applicant found potential errors in the population by age cohort data reported by the UT Center for Business and Economic Research Pop Projections. Due to these questions, the applicant has developed an alternative, age-adjusted methodology to project the need for geriatric inpatient beds in the six-county service area and using Nielsen Claritas population data.

To project need, a statewide age-adjusted use rate was determined, using actual geriatric psych patient volumes from the 2012 TN Joint Annual Reports, the most recent complete year of data. This amounted to a use rate of 15,007 geriatric psych patient days per 100,000 population statewide. This is the equivalent of a need for 41.1 geriatric psych beds per 100,000 population statewide at full occupancy. Assuming a 70% desired occupancy rate, this equates to a need for 58.7 geriatric psych beds per 100,000 population (41.1 /

0.70). Next, this use rate was applied to the six-county service area geriatric population for Year 2 of the proposed project (2016). To correct for apparent data inaccuracies, the applicant relied on Nielsen Claritas population data for these projections. This results in a gross need for 18.5 geriatric psych beds by 2016 at 70% desired occupancy. Existing service area beds were then taken into account to arrive at a net bed need. This results in a deficit of 8.5 geriatric psych beds in the six-county service area by Year 2 of the proposed project. In this application, the applicant requests the conversion of 10 existing medical-surgical beds to geriatric psych beds to meet this need ($8.5 + 1$ seclusion bed = $9.5 = 10$ bed program). Please see the detailed analysis below.

**RPH Six-county Service Area
Age-Adjusted Geriatric Psych Bed Need Analysis**

	2012
Tennessee patients days, age 65+	136,433
Nielsen Claritas TN population, age 65+	909,137
Patient days/100k pop (65+)	15,007
ADC	41.1 /100,000 65+
Beds @ 70% occupancy	58.7 /100,000 65+
Year 2	2016
6-County Service Area	31,462 65+ Pop
Beds @ 70% occupancy	58.7 /100,000 65+
Gross Need	18.5 beds
Existing inventory	10.0 beds
Net Need	8.5 beds

2. For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.

RESPONSE: Not applicable. This project proposes the development of geriatric psychiatric beds.

3. For child inpatient under age 13, and if adolescent program the age group of 13-17 should be used.

RESPONSE: Not applicable. This project proposes the development of geriatric psychiatric beds.

4. These estimates for total need should be adjusted by the existent staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.

RESPONSE: Noted above. Both existing and approved beds were used in the calculations for adult geriatric psychiatric beds, resulting in an unmet net need for 8.5 additional beds by 2016. RPH's proposed 10 bed geriatric psychiatric program will meet this service area need ($8.5 + 1$ seclusion bed = $9.5 = 10$ beds).

B. Service Area

1. The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.

RESPONSE: Based on historical patient origin data, RPH's service area for this project is comprised of 6 counties. These include Warren County as the primary service area, with the five other counties comprising the secondary service area. These include Dekalb, White, Van Buren, Grundy, and Coffee Counties. This service area represents over 96% of RPH's inpatient discharges in 2012.

2. The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.

RESPONSE: The anticipated growth in the 65 and older population within the service area is very strong, nearly eight times that of the total growth. Between 2014 and 2019, the elderly population is expected to increase 14.5%, or by 4,026 residents. For Tennessee, the total five-year growth within this age cohort is projected to be 19.3%, for the United States, 18.0%. Because the elderly are the target users of geriatric psych services, such an explosive growth rate foretells the need for RPH to anticipate increasing demand for these services.

C. Relationship to Existing Applicable Plans

1. The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.

RESPONSE: This project is consistent with all "Five Principles for Achieving Better Health" as listed in the 2012 Tennessee State Health Plan.

This project will improve the health of Tennesseans by expanding highly specialized geriatric psychiatric services to the segment of the population projected to experience the greatest growth through 2030.

The initiation of ten beds will provide reasonable access to health care by reducing the number of geriatric patients who would normally be forced to travel outside the area for care.

This project will help address the needs of Tennesseans ... and the continued development of the state's health care system by focusing on the geriatric subset of the adult psychiatric population which also has the greatest utilization of all inpatient services.

This project will assure every citizen that the quality of health care is continually monitored and standards are adhered to by maintaining full licensure and accreditation.

This project support(s) the development, recruitment, and retention of a sufficient and quality health care workforce by utilizing the services of existing

staff.

2. The proposal's relationship to underserved geographic areas and underserved population groups as identified in state, city, county and/or regional plans and other documents should be a significant consideration.

RESPONSE: As demonstrated in the need section of this application, RPH's project will serve an unmet need for geriatric psych services.

3. The impact of the proposal on similar services supported by state appropriations should be assessed and considered.

RESPONSE: Due to the need for services demonstrated in the area, the initiation of geriatric psych services at River Park Hospital is not expected to have a significant impact on their sister-facility, Highlands Medical Center.

4. The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.

RESPONSE: RPH will accept all patients requiring inpatient psychiatric care, whether the admission is voluntary or involuntary. While the proposed project is designed for acute psychiatric care, the hospital does anticipate admitting some patients needing longer term care. The hospital will admit these patients, and when stabilized, will assist in placing these patients into a clinically appropriate long-term care setting.

5. The degree of projected financial participation in the Medicare and TennCare programs should be considered.

RESPONSE: RPH currently accepts Medicare and TennCare patients, and will continue to do so upon completion of the proposed project.

D. Relationship to Existing Similar Services in the Area

1. The area's trends in occupancy and utilization of similar services should be considered.

RESPONSE: As detailed in the need methodology above, there is a clear need in the service area for the beds proposed in this application.

2. Accessibility to specific special need groups should be an important factor.

RESPONSE: The RPH geriatric psych program will serve patients who are often viewed as underserved by psychiatric providers, including:

- violent patients if capacity is available and the patient is otherwise a candidate for treatment
- patients with a financial class of TennCare or who are otherwise medically indigent
- patients who are geriatric and have special additional needs

- patients with complex medical co-morbidities such as dialysis, IV fluids, total parenteral nutrition, detoxification and urinary tract infections.

E. Feasibility

The ability of the applicant to meet Tennessee Department of Mental Health licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) should be considered.

RESPONSE: RPH will remain compliant with all Tennessee Department of Mental Health licensure requirements.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

RESPONSE: This project is consistent with the following general, long-range development guidelines of RPH:

- improve the health status of the service area population
- provide services that are needed by the community
- maintain quality healthcare services
- provide healthcare services cost-effectively.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. **Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

RESPONSE: Based on historical patient origin data, RPH's service area for this project is comprised of 6 counties. These include Warren County as the primary service area, with the remaining five counties comprising the secondary service area. These include Dekalb, White, Van Buren, Grundy, and Coffee Counties. This service area represents over 96% of RPH's inpatient discharges in 2012. Please see **Attachment B, III.(B).1 (Tab 8)** for a map depicting the service area.

4. A. Describe the demographics of the population to be served by this proposal.

RESPONSE: Between 2014 and 2019, the population of the service area is projected to increase by 1.9%, or by 3,035 residents. This represents an annual growth rate of 0.4% and is lower than the projected growth rate of the state as a whole within that same five-year period, which is 0.7% annually or 3.8% total growth. Please see **EXHIBIT 2**, which illustrates the projected changes in population of the service area between 2014 and 2019 and denotes population growth within the state of Tennessee, and the United States.

EXHIBIT 2
TOTAL POPULATION PROJECTIONS

	Total Population				
	2014	2019	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Warren County	39,764	40,059	295	0.1%	0.7%
Subtotal PSA	39,764	40,059	295	0.1%	0.7%
Secondary Service Area					
Coffee County	53,526	54,843	1,317	0.5%	2.5%
DeKalb County	19,023	19,528	505	0.5%	2.7%
Grundy County	13,626	13,700	74	0.1%	0.5%
Van Buren County	5,740	6,031	291	1.0%	5.1%
White County	26,168	26,721	553	0.4%	2.1%
Subtotal SSA	118,083	120,823	2,740	0.5%	2.3%
Total Service Area	157,847	160,882	3,035	0.4%	1.9%
Tennessee	6,531,577	6,778,877	247,300	0.7%	3.8%
United States	317,199,353	328,309,464	11,110,111	0.7%	3.5%

SOURCE: NIELSEN, INC.

The anticipated growth in the 65 and older population within the service area is much greater, nearly eight times that of the total growth. Between 2014 and 2019, the elderly population is expected to increase 14.5%, or by 4,026 residents. For Tennessee, the total five-year growth within this age cohort is projected to be 19.3%, for the United States, 18.0%. Because the elderly are the target users of geriatric psych services, such an explosive growth rate foretells the need for RPH to anticipate increasing demand for these services. Please see **EXHIBIT 3**.

**EXHIBIT 3
65 AND OLDER POPULATION PROJECTIONS**

	65+ Population				
	2014	2019	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Warren County	6,524	7,406	882	2.6%	13.5%
Subtotal PSA	6,524	7,406	882	2.6%	13.5%
Secondary Service Area					
Coffee County	9,118	10,396	1,278	2.7%	14.0%
DeKalb County	3,288	3,853	565	3.2%	17.2%
Grundy County	2,636	2,979	343	2.5%	13.0%
Van Buren County	1,101	1,326	225	3.8%	20.4%
White County	5,030	5,763	733	2.8%	14.6%
Subtotal SSA	21,173	24,317	3,144	2.8%	14.8%
Total Service Area	27,697	31,723	4,026	2.8%	14.5%
Tennessee	968,443	1,155,791	187,348	3.6%	19.3%
United States	45,157,410	53,278,626	8,121,216	3.4%	18.0%

SOURCE: NIELSEN, INC.

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

RESPONSE: RPH has a history of providing high quality healthcare that is accessible to all segments of the community. It provides services without regard to gender, race, socio-economic status, or ability to pay, and participates in the Medicare and TennCare programs.

In 2014, the 65 and older population accounted for 17.6% of the total population in the service area. As a major demographic subgroup of RPH's patient base, the elderly will continue to expect of RPH the same level of service while becoming an increasingly larger segment of the total service area population, with 2019 projections placing the 65 and older population at 19.7% of the total service area population.

The female population will represent 50.9% of the total population in the service area by 2019. As shown in **EXHIBIT 4**, the female population is expected to grow at the same annual rate as both sexes in service area, 0.4% per year.

EXHIBIT 4
FEMALE POPULATION PROJECTIONS

	Female Population				
	2014	2019	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Warren County	20,108	20,243	135	0.1%	0.7%
Subtotal PSA	20,108	20,243	135	0.1%	0.7%
Secondary Service Area					
Coffee County	27,516	28,172	656	0.5%	2.4%
DeKalb County	9,590	9,841	251	0.5%	2.6%
Grundy County	6,892	6,921	29	0.1%	0.4%
Van Buren County	2,886	3,033	147	1.0%	5.1%
White County	13,351	13,623	272	0.4%	2.0%
Subtotal SSA	60,235	61,590	1,355	0.4%	2.2%
Total Service Area	80,343	81,833	1,490	0.4%	1.9%
Tennessee	3,345,908	3,468,589	122,681	0.7%	3.7%
United States	161,080,583	166,596,352	5,515,769	0.7%	3.4%

SOURCE: NIELSEN, INC.

EXHIBITS 5-7 illustrate the racial composition of the RPH service area. By 2019, the white population will comprise 89.6% of the total population of the service area, while the black population will account for 4.2% and other races, 6.1%.

EXHIBIT 5
WHITE POPULATION PROJECTIONS

	White Population				
	2014	2019	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Warren County	35,046	34,586	-460	-0.3%	-1.3%
Subtotal PSA	35,046	34,586	-460	-0.3%	-1.3%
Secondary Service Area					
Coffee County	48,609	48,955	346	0.1%	0.7%
DeKalb County	17,266	17,227	-39	0.0%	-0.2%
Grundy County	13,175	13,051	-124	-0.2%	-0.9%
Van Buren County	5,582	5,800	218	0.8%	3.9%
White County	24,627	24,569	-58	0.0%	-0.2%
Subtotal SSA	109,259	109,602	343	0.1%	0.3%
Total Service Area	144,305	144,188	-117	0.0%	-0.1%
Tennessee	5,008,888	5,123,236	114,348	0.5%	2.3%
United States	226,254,684	229,546,283	3,291,599	0.3%	1.5%

SOURCE: NIELSEN, INC.

EXHIBIT 6
BLACK POPULATION PROJECTIONS

	Black Population				
	2014	2019	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Warren County	1,401	1,760	359	4.7%	25.6%
Subtotal PSA	1,401	1,760	359	4.7%	25.6%
Secondary Service Area					
Coffee County	2,346	3,052	706	5.4%	30.1%
DeKalb County	409	633	224	9.1%	54.8%
Grundy County	135	268			
Van Buren County	69	135	66	14.4%	95.7%
White County	673	970	297	7.6%	44.1%
Subtotal SSA	3,632	5,058	1,426	6.8%	39.3%
Total Service Area	5,033	6,818	1,785	6.3%	35.5%
Tennessee	1,102,940	1,163,366	60,426	1.1%	5.5%
United States	40,263,108	42,033,755	1,770,647	0.9%	4.4%

SOURCE: NIELSEN, INC.

EXHIBIT 7
"OTHER" POPULATION PROJECTIONS

	"Other" Population				
	2014	2019	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Warren County	3,317	3,713	396	2.3%	11.9%
Subtotal PSA	3,317	3,713	396	2.3%	11.9%
Secondary Service Area					
Coffee County	2,571	2,836	265	2.0%	10.3%
DeKalb County	1,348	1,668	320	4.4%	23.7%
Grundy County	316	381	65	3.8%	20.6%
Van Buren County	89	96	7	1.5%	7.9%
White County	868	1,182	314	6.4%	36.2%
Subtotal SSA	5,192	6,163	971	3.5%	18.7%
Total Service Area	8,509	9,876	1,367	3.0%	16.1%
Tennessee	419,749	492,275	72,526	3.2%	17.3%
United States	50,681,561	56,729,426	6,047,865	2.3%	11.9%

SOURCE: NIELSEN, INC.

The service area counties as a whole have a Median Household Income far lower than that of the state of Tennessee, and the United States. Additionally, five year projections for median household income in the service area show a large decrease, whereas Tennessee shows a slight decrease, and the United States an overall gain. Please see EXHIBIT 8.

EXHIBIT 8
SERVICE AREA MEDIAN HOUSEHOLD INCOME

	Median Household Income				
	2014	2019	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Warren County	\$34,464	\$29,898	-4,566	-2.8%	-13.2%
Subtotal PSA	\$34,464	\$29,898	-4,566	-2.8%	-13.2%
Secondary Service Area					
Coffee County	\$35,672	\$29,489	-6,183	-3.7%	-17.3%
DeKalb County	\$38,336	\$29,453	-8,883	-5.1%	-23.2%
Grundy County	\$27,310	\$22,217			
Van Buren County	\$32,091	\$26,856	-5,235	-3.5%	-16.3%
White County	\$34,819	\$30,030	-4,789	-2.9%	-13.8%
Subtotal SSA	\$33,646	\$27,609	-6,037	-3.9%	-17.9%
Total Service Area	\$33,782	\$27,991	-5,792	-3.7%	-17.1%
Tennessee	\$43,390	\$43,130	-260	-0.1%	-0.6%
United States	\$51,579	\$53,666	2,087	0.8%	4.0%

SOURCE: NIELSEN, INC.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

RESPONSE: There is currently only one service area provider of geriatric psychiatry services, Highlands Medical Center.

Facility	Beds	Patient Days			ADC		
		2010	2011	2012	2010	2011	2012
Highlands Medical Center	10	245	267	3,059	0.7	0.7	8.4

Source: TN JARs

Highlands Medical Center is well utilized and had an average daily census of 8.4 patients (83.8% occupancy) in 2012. With this Certificate of Need application, River Park Hospital seeks to initiate geriatric psychiatry services to meet the needs of service area patients. As demonstrated in the need analysis earlier in this application, there is more than sufficient service area volume to support this proposed project.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

RESPONSE: Please see **EXHIBIT 9** below for RPH's projected geriatric psychiatric patient days for Years 1 and 2:

EXHIBIT 9
PROJECTED PSYCHIATRIC PATIENT DAYS, 2015-2016

	Historical			Projected	
	2011	2012	2013	2015	2016
Patient Days	N/A	N/A	N/A	2,293	2,752

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.
 - All projects should have a project cost of at least \$3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)
 - The cost of any lease (building, land and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. NOTE: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.
 - The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.
 - For projects that include new construction, modification, and/or renovation; **documentation must be** provided from a contractor and/or architect that support the estimated construction costs.

RESPONSE: Please see **Attachment C, Economic Feasibility – 1 (Tab 10)** for a letter from the contractor supporting the construction costs.

PROJECT COSTS CHART

A. Construction and equipment acquired by purchase:

1.	Architectural and Engineering Fees	<u>\$80,000</u>
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	<u>50,000</u>
3.	Acquisition of Site	<u> </u>
4.	Preparation of Site	<u>2,500</u>
5.	Construction Costs	<u>975,000</u>
6.	Contingency Fund	<u>48,750</u>
7.	Fixed Equipment (Not included in Construction Contract)	<u>15,000</u>
8.	Moveable Equipment (List all equipment over \$50,000)	<u>25,000</u>
9.	Other (Moving, logistics, etc)	<u> </u>

B. Acquisition by gift, donation, or lease:

1.	Facility (inclusive of building and land)	<u> </u>
2.	Building only	<u> </u>
3.	Land only	<u> </u>
4.	Equipment (Specify) _____	<u> </u>
5.	Other (Specify) _____	<u> </u>

C. Financing Costs and Fees:

1.	Interim Financing	<u> </u>
2.	Underwriting Costs	<u> </u>
3.	Reserve for One Year's Debt Service	<u> </u>
4.	Other (Specify) _____	<u> </u>

D. Estimated Project Cost \$1,196,250
(A+B+C)

E. CON Filing Fee 3,000

F. Total Estimated Project Cost 1,199,250
(D+E)

TOTAL \$1,199,250 July 2014
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2. Identify the funding sources for this project.
Please check the applicable item(s) below and briefly summarize how the project will be financed.
(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)
- ☐ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;
 - ☐ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;
 - ☐ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.
 - ☐ D. Grants--Notification of intent form for grant application or notice of grant award; or
 - ☒ E. Cash Reserves (Tab 11) (\$1.1M from reserves, Balance from Operating Income)
 - ☐ F. Other—Identify and document funding from all other sources.
3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

RESPONSE: The renovation cost for the proposed project averages \$192.46 per square foot but is not easily comparable to other Tennessee projects. This is due to the relatively small amount of space requiring renovation – only 5,066 square feet. Any minor differences in scope from one project to another (e.g., renovation or new construction) can result in significant average cost per square foot estimates when dealing with such small areas of space.

Exhibit 10, below, lists the average costs for recently approved CON projects statewide between 2011 and 2013. The construction costs per square foot for these projects have quite a large range of variability. Regardless, the expenditure requested by RPH's renovation project (\$192.46) falls within the mid-range of projects previously reviewed by the Health Services and Development Agency and are reasonable for the scope of work proposed.

**EXHIBIT 10
HOSPITAL CONSTRUCTION COST PER SQUARE FOOT
2011 - 2013**

	Renovated Construction	New Construction	Total Construction
1st Quartile	\$107.15/sq ft	\$235.00/sq ft	\$151.56/sq ft
Median	\$179.00/sq ft	\$274.63/sq ft	\$227.88/sq ft
3rd Quartile	\$249.00/sq ft	\$324.00/sq ft	\$274.63/sq ft

Source: CON approved applications for years 2011 through 2013

4. Complete Historical and Projected Data Charts on the following two pages--**Do not modify the Charts provided or submit Chart substitutions!** Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

RESPONSE: Please refer to the completed charts on pages 32 through 35.

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

RESPONSE: Average gross patient charge per patient day based on Year 2 projections (2016), is \$2,994. The average deduction from gross patient charges, based on contractual allowances only and excluding allowances for charity care and bad debt, is \$2,158, resulting in an average net charge per patient day of \$836.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in May.

	Year 2011	Year 2012	Year 2013
A. Utilization Data (Patient Days)	<u>13,695</u>	<u>11,625</u>	<u>11,395</u>
B. Revenue from Services to Patients			
1. Inpatient Services	<u>\$86,903,715</u>	<u>\$79,198,333</u>	<u>\$82,972,695</u>
2. Outpatient Services	<u>122,601,900</u>	<u>130,968,409</u>	<u>137,921,985</u>
3. Emergency Services	<u></u>	<u></u>	<u></u>
4. Other Operating Revenue (Specify)	<u>1,113,749</u>	<u>617,187</u>	<u>574,163</u>
Gross Operating Revenue	<u>\$210,619,364</u>	<u>\$210,783,929</u>	<u>\$221,468,843</u>
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	<u>\$159,469,902</u>	<u>\$160,219,829</u>	<u>\$170,277,516</u>
2. Provision for Charity Care	<u>445,533</u>	<u>865,289</u>	<u>994,575</u>
3. Provisions for Bad Debt	<u>6,116,451</u>	<u>7,857,386</u>	<u>7,928,009</u>
Total Deductions	<u>\$166,031,886</u>	<u>\$168,942,504</u>	<u>\$179,200,100</u>
NET OPERATING REVENUE	<u>\$44,587,478</u>	<u>\$41,841,425</u>	<u>\$42,268,743</u>
D. Operating Expenses			
1. Salaries and Wages	<u>\$14,807,689</u>	<u>\$14,489,413</u>	<u>\$14,879,419</u>
2. Physician's Salaries and Wages	<u>\$1,240,555</u>	<u>856,660</u>	<u>330,004</u>
3. Supplies	<u>13,088,089</u>	<u>12,771,481</u>	<u>13,174,728</u>
4. Taxes	<u>2,239,381</u>	<u>2,425,371</u>	<u>2,506,589</u>
5. Depreciation	<u>2,377,527</u>	<u>2,363,707</u>	<u>2,788,046</u>
6. Rent	<u>516,697</u>	<u>539,515</u>	<u>508,688</u>

7	Interest, other than Capital	<u>3,790,733</u>	<u>3,791,608</u>	<u>3,789,876</u>
8	Management Fees:			
	a. Fees to Affiliates	<u>919,548</u>	<u>1,026,331</u>	<u>427,007</u>
	b. Fees to Non-Affiliates	<u></u>	<u></u>	<u></u>
9	Other Expenses (Specify)			
	Employee Benefits	<u>3,679,733</u>	<u>4,174,297</u>	<u>3,991,881</u>
	Professional Fees	<u>1,283,194</u>	<u>2,273,538</u>	<u>2,820,501</u>
	Contracted Nursing Services	<u>217,044</u>	<u>88,576</u>	<u>258,938</u>
	Energy Expense	<u>1,170,786</u>	<u>1,184,897</u>	<u>1,221,083</u>
	Total Operating Expenses	<u>\$45,330,976</u>	<u>\$45,985,394</u>	<u>\$46,696,760</u>
E.	Other Revenue (Expenses) - Net (Specify)	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>
	NET OPERATING INCOME (LOSS)	<u>(743,498)</u>	<u>(4,143,969)</u>	<u>(4,428,017)</u>
F.	Capital Expenditures			
	1 Retirement of Principal	<u></u>	<u></u>	<u></u>
	2 Interest	<u></u>	<u></u>	<u></u>
	Total Capital Expenditures	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>
	NET OPERATING INCOME (LOSS)			
	LESS CAPITAL EXPENDITURES	<u>(\$743,498)</u>	<u>(\$4,143,969)</u>	<u>(\$4,428,017)</u>

PROJECTED DATA CHART

Give us information for the *two (2)* years following the completion of this proposal. The fiscal year begins in May. Data for proposed new service only.

	2015	2016
A. Utilization Data (Patient Days)	<u>2,293</u>	<u>2,752</u>
B. Revenue from Services to Patients		
1. Inpatient Services	<u>\$6,478,290</u>	<u>\$8,240,385</u>
2. Outpatient Services	<u>0</u>	<u>0</u>
3. Emergency Services	<u>0</u>	<u>0</u>
4. Other Operating Revenue (Specify)	<u>0</u>	<u>0</u>
Gross Operating Revenue	<u>\$6,478,290</u>	<u>\$8,240,385</u>
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	<u>\$4,511,642</u>	<u>\$5,880,407</u>
2. Provision for Charity Care	<u>19,371</u>	<u>23,246</u>
3. Provisions for Bad Debt	<u>29,500</u>	<u>35,400</u>
Total Deductions	<u>\$4,560,513</u>	<u>\$5,939,053</u>
NET OPERATING REVENUE	<u>\$1,917,777</u>	<u>\$2,301,332</u>
D. Operating Expenses		
1. Salaries and Wages	<u>\$1,118,032</u>	<u>\$1,140,392</u>
2. Physician's Salaries and Wages	<u></u>	<u></u>
3. Supplies	<u>50,255</u>	<u>61,513</u>
4. Taxes	<u></u>	<u></u>
5. Depreciation	<u>65,000</u>	<u>65,000</u>
6. Rent	<u>6,000</u>	<u>6,000</u>

7.	Interest, other than Capital	<u> </u>	<u> </u>
8.	Management Fees:		
	a. Fees to Affiliates	<u> </u>	<u> </u>
	b. Fees to Non-Affiliates	<u> </u>	<u> </u>
9.	Other Expenses (Specify)		
	Professional Fees	<u>100,000</u>	<u>100,000</u>
	Purchased Services	<u>51,333</u>	<u>59,200</u>
	Utilities and Maintenance	<u>11,400</u>	<u>11,400</u>
	Insurance	<u>18,000</u>	<u>18,000</u>
	Other: Ancillary Expenses	<u>135,733</u>	<u>135,600</u>
	Total Operating Expenses	<u>\$1,555,753</u>	<u>\$1,597,105</u>
E.	Other Revenue (Expenses) -- Net (Specify)	<u> </u>	<u> </u>
	NET OPERATING INCOME (LOSS)	<u>\$362,024</u>	<u>\$704,227</u>
F.	Capital Expenditures		
1.	Retirement of Principal	<u>\$0</u>	<u>\$0</u>
2.	Interest	<u>0</u>	<u>0</u>
	Total Capital Expenditures	<u>\$0</u>	<u>\$0</u>
	NET OPERATING INCOME (LOSS)		
	LESS CAPITAL EXPENDITURES	<u>\$362,024</u>	<u>\$704,227</u>

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

RESPONSE: As a new service, RPH does not have historical geriatric psych charge data. Exhibit 11.A, below, represents projected charges for Year 1 and 2 following project completion.

**EXHIBIT 11.A
RPH GERI PSYCH PROJECTED CHARGES**

	Historical			Projected	
	2012	2013	2014	2015	2016
Avg Gross Charge per Patient Day	N/A	N/A	N/A	\$2,825	\$2,994

Source: RPH Projections

- B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

RESPONSE: RPH's projected charges are very competitive when compared to the only other provider of geriatric psych services in the service area.

**EXHIBIT 11.B
AVERAGE GROSS CHARGE PER PATIENT DAY COMPARISON – EXISTING AREA PROVIDERS**

Hospital	2013
Highlands Medical Center	\$2,800

Source: Joint Annual Report of Hospitals

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

RESPONSE: As indicated in the Projected Data Chart, projected utilization will be sufficient to allow RPH to operate efficiently and effectively.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

RESPONSE: As indicated in the Projected Data Chart, projected cash flow will ensure financial viability within two years and over the long-term. The projected positive cash flows generated by the geriatric psychiatric program will also be beneficial to the hospital's overall financial health.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

RESPONSE: RPH currently participates in both the Medicare and TennCare/Medicaid programs and has a history of providing care regardless of payor source. Using 2013 JAR data, RPH had a payor mix (based on gross charges) that was 49.3% Medicare and 22.7% TennCare. Additionally,

RPH provided \$994,575 in care to charity/medically indigent patients (accounting for 2.0% of net patient charges of \$49,326,905). During the first year of operation of the proposed project, the RPH payor mix is anticipated to remain at historical levels.

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

RESPONSE: Please see **Attachment C, Economic Feasibility – 10 (Tabs 12 & 13).**

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

- a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

RESPONSE: RPH considered three options when evaluating this project.

- First, maintaining the status quo will not address the need for geriatric psychiatric services in the service area.
- Second, expanding outside the RPH campus is not financially feasible. Not only would initial facility costs vastly exceed the proposed renovation costs, but on-going operating expenses would be higher if two locations were offered rather than just one program at a single location
- Third, renovation of existing space was deemed to be the most appropriate use of facility, financial and staff resources. Affected areas will include 6 former patient rooms located on the third floor which are currently held for overflow patients. This project proposes to renovate these rooms for reuse as patient rooms. Only minor renovations are required to modify the space for geriatric psychiatric use. Furthermore, existing staff and management can be effectively and efficiently leveraged through the 10 bed conversion.

- b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

RESPONSE: Not applicable. This project does not involve new construction, only renovated space in the existing hospital.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

RESPONSE:

Managed Care Contracts

- BCBS ACCESS TN
- AETNA HMO
- AETNA PPO
- AETNA LIMITED BENEFIT PLN
- AETNA National Advantage Program
- TNCARE AMERIGROUP
- BEECH STREET
- BEECHSTREET PPO LIMITED
- BCBS TN NETWORK P CAPELLA
- BLUE CROSS NETWORK PREFERRED
- BLUE CROSS TN NETWORK SELECT
- BLUE CROSS FEDERAL EMPLOYEE PLAN
- TNCARE BLUECARE
- TNCARE SELECT
- BLUE CROSS OUT OF ST 2
- BUYERS HEALTHCARE
- BLUEGRASS SINGLESOURCE
- BENESIGHT
- CIGNA PPO
- CIGNA HMO
- CIGNA POS FLEXCARE
- CIGNA PPO LIMITED BENEFIT
- CIGNA STATE OF TN EMPL
- BCBS COVER TN
- COVENTRY HEALTHCARE
- FIRST HEALTH
- FIRST HTH LIMITED BENEFIT
- GOVT EMPLOYEES HLTH ASSN
- GREAT WEST HMO
- GREAT WEST POS
- GREAT WEST PPO
- HEALTHSPRING PLUS
- HEALTHSPRING MCARE PLUS
- HEALTHSPRING MCARE PPO
- LAZARUS HOUSE
- HUMANA CHOICECARE
- ODOMS TN PRIDE HLTH COST
- LIFEPOINT HOSPITALS
- MAILHANDLERS
- MULTIPLAN
- MULTIPLAN CINERGY HEALTH
- MULTIPLAN LIMITED BENEFIT

- NOVANET PPO
- PRIME HEALTH SERVICES
- WORK COMP PRIME HEALTH
- PHCS
- PHCS LIMITED PLAN
- PRO AMERICA BEN LOMAND TE
- PLUMBERS PIPE LOCAL 572
- SIGNATURE HEALTH
- HEALTHSPRING TICUA
- THREE RIVERS NTWK TRPN
- UNITED HEALTHCARE HMO
- UNITED HEALTHCARE PPO
- UHC GOLDEN RULE
- UHC PACIFICARE HLTH SYS
- UNITED HEALTHCARE NISSAN
- UHC AMERICAN MED SEC
- UHC MIDATLANTIC MEDICAL
- UHC OXFORD HEALTH PLANS
- UHC NEIGHBORHOOD HLTH
- UNITED HC RED KAPP
- UHC DEFINITY HEALTH
- UNITED MEDICAL RESOURCES
- UHC OF THE RIVER VALLEY
- UHC STATE OF TN EMPLOYEE
- TC UHC COMMUNITY PLN RET
- TC UHC COMMUNITY PLAN
- USA MANAGED CARE
- BLUE CROSS SC CAPELLA EMP
- PCIP PRE EXISTING COND

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

RESPONSE: The state need projections for psychiatric inpatient services of 30 beds per 100,000 general population do not adequately reflect the need for geriatric psychiatric services in the proposed service area. As with general acute care beds, elderly patients utilize inpatient psychiatric services at a much higher rate than the general population. At the April 2014 HSDA CON meeting, representatives from both the Tennessee Department of Mental Health (Sandra Braber-Grove, Division of General Counsel) and the Division of Health Planning (Jeff Ockerman, Director-Division of Health Planning) both acknowledged that the current psychiatric bed need guidelines (30 beds/100,000 population) are inadequate.

As such, age-adjusted bed need projections show a much greater need for additional geriatric psychiatric beds in the service area. Additionally, when running the bed need projections for the six-county service area for 2012, the applicant found potential errors in the population by age cohort data reported by the UT Center for Business and Economic Research Pop Projections. Due to these questions, the applicant has developed an alternative, age-adjusted methodology to project the need for geriatric inpatient beds in the six-county service area and using Nielsen Claritas population data.

To project need, a statewide age-adjusted use rate was determined, using actual geriatric psych patient volumes from the 2012 TN Joint Annual Reports, the most recent complete year of data. This amounted to a use rate of 15,007 geriatric psych patient days per 100,000 population statewide. This is the equivalent of a need for 41.1 geriatric psych beds per 100,000 population statewide at full occupancy. Assuming a 70% desired occupancy rate, this equates to a need for 58.7 geriatric psych beds per 100,000 population ($41.1 / 0.70$). Next, this use rate was applied to the six-county service area geriatric population for Year 2 of the proposed project (2016). To correct for apparent data inaccuracies, the applicant relied on Nielsen Claritas population data for these projections. This results in a gross need for 18.5 geriatric psych beds by 2016 at 70% desired occupancy. Existing service area beds were then taken into account to arrive at a net bed need. This results in a deficit of 8.5 geriatric psych beds in the six-county service area by Year 2 of the proposed project. In this application, the applicant requests the conversion of 10 existing medical-surgical beds to geriatric psych beds to meet this need ($8.5 + 1$ seclusion bed = $9.5 = 10$ bed program).

Through the use of this bed need methodology, RPH has established that a need exists in the planning area for additional geriatric psychiatric beds. Since service area need has been established, this project will have a positive effect on the health care system.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

RESPONSE: This project will require a 6.3 FTE increase in registered nurses at the hospital. By shifting manpower within the Capella system, RPH can fill these FTE requirements internally using existing staffing. However, if outside staffing becomes necessary in the future, in addition to its existing educational affiliations, RPH will utilize a number of channels to secure needed staff including in-house listings of available positions, advertisements in local and regional newspapers, advertisements in professional publications, and recruiting firms. RPH has a history of successfully recruiting professional and administrative staff because it provides competitive benefits, compensation, and is committed to the retention of existing personnel.

EXHIBIT 12 illustrates proposed staffing levels of the proposed project. Across all positions, staffing is projected to be 20.0 FTEs in the second year of operation. EXHIBIT 13 profiles comparable positions and salaries for the North Central Tennessee nonmetropolitan area (NCTNA), which contains the proposed service area counties. RPH's salaries and wages are competitive with the market. Proposed annual salaries for registered nurses with 5-7 years of experience are \$55,120, or within 1% of the NCTNA median.

EXHIBIT 12
PROPOSED STAFFING LEVELS
(FULL TIME EQUIVALENTS)

Position	Proposed
RN	6.3
Nursing Assistant	4.2
LPN	2.1
AT/RT	1.4
Director of Geri-Psych	1.0
Nurse Manager	1.0
Community Education Manager	1.0
Social Worker	1.0
Program/Unit Secretary	1.0
ER Assessment RN	1.0

EXHIBIT 13
NORTH CENTRAL TENNESSEE NONMETROPOLITAN AREA

North Central Tennessee nonmetropolitan area, May 2013		
Occupational Title	Mean	Median
Registered Nurses	\$55,869	\$55,640

Source: Annual Salary BLS Occupational Employment Statistics Survey Data

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

RESPONSE: This project has only a minimal need for additional staffing. A number of channels are utilized, including in-house listings of available positions, advertisements in local and regional newspapers, advertisements in professional publications, and recruiting firms. RPH has a history of successfully recruiting professional and administrative staff. It provides competitive benefits, compensation, and is committed to the retention of existing personnel.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.

RESPONSE: RPH has reviewed and understands the licensure and certification requirements for medical and clinical staff. As an existing licensed and Joint Commission-accredited facility, RPH has administrative policies and procedures in place to ensure that licensure and certification requirements are followed. Furthermore, RPH maintains quality standards that are focused on continual improvement. Please see **Attachment C, Contribution to the Orderly Development of Health Care – 5** for copies of its Quality and Patient Safety Improvement Plan (**Tab 14**), and Utilization Review Plan (**Tab 15**) and Patient Bill of Rights (**Tab 16**).

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

RESPONSE: RPH is open to participation with any area teaching and training programs requesting assistance.

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

RESPONSE: As an existing hospital, RPH is licensed by the Tennessee Department of Health. RPH has reviewed and understands the licensure requirements.

- (b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: Board of Licensing Health Care Facilities, State of Tennessee, Department of Health.

Accreditation: RPH is accredited by The Joint Commission (on Accreditation of Healthcare Organizations). Please see **Attachment C, Contribution to the Orderly Development of Health Care – 7.(b) (Tab 17)** for the most recent report.

- (c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

RESPONSE: Please see **Attachment C, Contribution to the Orderly Development of Health Care – 7.(c) (Tab 18)**. The current license is valid until April 8, 2015.

- (d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

RESPONSE: The hospital is in compliance with all applicable licensure requirements. Please see **Attachment C, Contribution to the Orderly Development of Health Care – 7.(b) (Tab 17)** for RPH's most recent accreditation report completed by The Joint Commission (on Accreditation of Healthcare Organizations).

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

RESPONSE: There have been no final orders or judgments placed against RPH or any entity or person with more than 5 percent ownership.

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project

RESPONSE: There have been no civil or criminal judgments against RPH or any entity or person with more than 5% ownership.

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number, and type of procedures performed, and other data as required.

RESPONSE: Yes, RPH will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number, and type of procedures performed, and other data as required. Additionally, RPH submits a Joint Annual Report (JAR) to the Department of Health and will continue to do so.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

Please see Attachment D – Proof of Publication (Tabs 19-20).

DEVELOPMENT SCHEDULE

Tennessee Code Annotated §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.
2. If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.

RESPONSE: The project completion schedule below reflects the anticipated schedule for the geriatric psychiatric bed conversion project.

Form HF0004
Revised 02/01/06
Previous Forms are obsolete

PROJECT FORECAST COMPLETION CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): Oct 22, 2014

Assuming the CON approval becomes the final agency action on that date; indicate the number of days from the above agency decision date to each phase of the completion forecast.

<u>Phase</u>	<u>DAYS REQUIRED</u>	<u>Anticipated Date (MONTH/YEAR)</u>
1. Architectural and engineering contract signed	0	Oct-14
2. Construction documents approved by the Tennessee Department of Health	30	Nov-14
3. Construction contract signed	30	Nov-14
4. Building permit secured	45	Dec-14
5. Site preparation completed	N/A	
6. Building construction commenced	60	Dec-14
7. Construction 40% complete	120	Feb-15
8. Construction 80% complete	150	Mar-15
9. Construction 100% complete (approved for occupancy)	180	Apr-15
10. *Issuance of license	180	Apr-15
11. *Initiation of service	180	Apr-15
12. Final Architectural Certification of Payment	210	May-15
13. Final Project Report Form (HF0055)	240	Jun-15

* For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

AFFIDAVIT

STATE OF Tennessee

COUNTY OF Warren

Joseph Mazzo being first duly sworn, says that he/she is the applicant named in this application or his/her lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Joseph Mazzo COO
SIGNATURE/TITLE

Sworn to and subscribed before me this 3rd day of July, 2014 a Notary
(Month) (Year)

Public in and for the County/State of Warren County, Tennessee



Susan D. Ford
NOTARY PUBLIC

My commission expires March 8, 2015
(Month/Day) (Year)



Capella Healthcare, INC
DBA: River Park Hospital, INC
Special Business Account
1559 Sparta Street
McMinnville TN 37110

32-1/1110 TX

Check No. 13100225

Date 7/03/2014

Pay to the
Order of Health Services & Development Agency

\$3,000.00*

Three Thousand and 00/100*****

Dollars

BANK OF AMERICA

Memo Geri-psych CON

Record of Payment Check: 13100225 Payee: Health Services & Development Agency 7/03/2014

Capella Healthcare

Geri-psych CON

\$3,000.00*

Record of Payment Check: 13100225 Payee: Health Services & Development Agency 7/03/2014

Capella Healthcare

Geri-psych CON

000048

\$3,000.00*

REORDER FORM #7200

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- Tab 3 - Board Roster
- Tab 4 - Certificate of Corporate Existence
- Tab 5 - Site Entitlement (Deed)
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Attachment B

- Tab 7 - Plot Plan
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Attachment C

- Tab 10 - Construction Costs Verification Letter
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- Tab 12 - Balance Sheet and Income Statement
- Tab 13 - Audited Financials
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- Tab 16 - Patient Bill of Rights
- Tab 17 - The Joint Commission Documentation
- Tab 18 - Hospital License

Attachment D

- Tab 19 - Copy of Published Public Notice
- Tab 20 - Letter of Intent

Attachment A

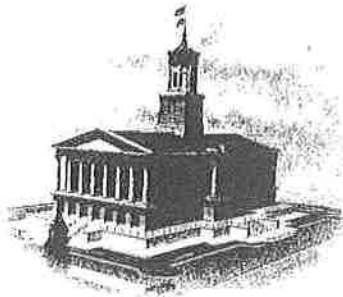
**Corporate Charter
Organizational Chart
Board Roster
Certificate of Corporate Existence
Deed
MCO/BHO Participation**

Tab 1

Attachment A, 3

Corporate Charter

State of Tennessee



Department of State

CERTIFICATE

The undersigned, as Secretary of State of the State of Tennessee, hereby certifies that the attached document was received for filing on behalf of RIVER PARK HOSPITAL, INC., was duly executed in accordance with
(Name of Corporation)
the Tennessee General Corporation Act, was found to conform to law and was filed by the undersigned, as Secretary of State, on the date noted on the document.

THEREFORE, the undersigned, as Secretary of State, and by virtue of the authority vested in him by law, hereby issues this certificate and attaches hereto the document which was duly filed on this August First, 1969.



James H. Cannon
Secretary of State

CHARTER
OF
RIVER PARK HOSPITAL, INC.

BOOK 4355 PAGE 636

The undersigned natural persons, having capacity to contract and acting as the incorporators of a corporation under the Tennessee General Corporation Act, adopt the following Charter for such corporation:

1. The name of the corporation is River Park Hospital, Inc.

2. The duration of the corporation is perpetual.

3. The address of the principal office of the corporation in the State of Tennessee shall be 242 25th Avenue, North, Nashville, County of Davidson.

4. The corporation is for profit.

5. The purposes for which the corporation is organized are:

1. To purchase, lease, or otherwise acquire, to operate, and to sell, lease or otherwise dispose of hospitals, convalescent homes, nursing homes and other institutions for the medical care and treatment of patients; to purchase, manufacture, or prepare and to sell or otherwise deal in, as principal or as agent, medical equipment and supplies; to construct, or lease, and to operate restaurants, drug stores, gift shops, office buildings, and other facilities in connection with hospitals or other medical facilities owned or operated by it; and

2. To purchase or otherwise acquire, to hold and to sell or otherwise dispose of the stocks, bonds and other securities of any corporation, foreign,

BOOK 4355 PAGE 637

or domestic; to exercise all powers and any or all rights and privileges of individual ownership or interest in respect to any and all such securities; to manage and to aid in any manner, by loan, guarantee, or otherwise, any corporation or corporations of which any securities are held by the corporation; and to do any and all acts or things necessary, expedient or calculated to protect, preserve or enhance the value of any such securities.

6. The maximum number of shares which the corporation shall have the authority to issue is One Thousand (1,000) shares, with \$1 par value.

7. The corporation will not commence business until the consideration of One Thousand Dollars (\$1,000) has been received for the issuance of shares.

8. (a) The shareholders of this corporation shall not have pre-emptive rights.

(b) The Board of Directors of this corporation shall consist of not less than three individuals, or of a number of individuals not less than the number of shareholders of this corporation, whichever amount is the lesser; members of the Board of Directors need not be shareholders of this corporation.

(c) Additional members of the Board of Directors may be elected by the shareholders at the annual meeting, and by a majority of the members of the entire Board of Directors at any other times; members of the Board of Directors of this corporation shall be elected for a term which shall extend until the date of the next annual meeting subsequent to their election to the Board of Directors.

(d) The Board of Directors of this corporation shall have the power to appoint an Executive Committee, consisting of not less than two persons, which committee shall have the

BOOK 4355 PAGE 638

power and authority to act in the place and stead of the Board of Directors during the intervals between the regular meetings of the Board of Directors.

(e) The majority of the members of the entire Board of Directors of this corporation shall have the power to remove any member of the Board of Directors for just cause.

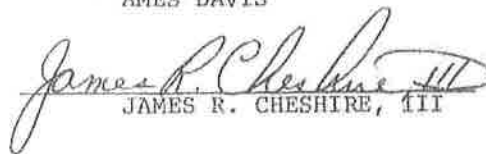
(f) The initial bylaws of this corporation shall be adopted by the incorporators hereof, and thereafter, the bylaws of this corporation may be amended, repealed or adopted by a majority of the members of the entire Board of Directors, or by the holders of a majority of the outstanding shares of capital stock.

(g) This corporation shall have the right and power to purchase and hold shares of its capital stock; provided however, that such purchase, whether direct or indirect, shall be made only to the extent of unreserved and unrestricted capital surplus.

Dated August 1, 1969.


WILLIAM E. MARTIN


AMES DAVIS


JAMES R. CHESHIRE, III

**ARTICLES OF AMENDMENT
TO THE RESTATED CHARTER OF
RIVER PARK HOSPITAL, INC.**

To the Secretary of the State of Tennessee:

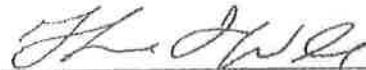
In accordance with the provisions of Section 48-20-106 of the Tennessee Business Corporation Act (the "Act"), River Park Hospital, Inc. (the "Corporation"), organized and existing under and by virtue of the provisions of the Act and all amendments thereto, does hereby submit this Amendment to its Restated Charter:

1. The name of the Corporation is River Park Hospital, Inc..
2. Article 8 subsection (b) of the Charter is deleted in its entirety and the following is substituted in lieu thereof:

The Board of Directors of this corporation shall consist of one to ten individuals; members of the Board of Directors need not be shareholders of this corporation

4. This amendment was duly authorized and adopted by the Board of Directors of the Corporation by written consent action taken effective as of February 28, 2008. The foregoing amendment did not require shareholder approval.

RIVER PARK HOSPITAL, INC.



Name: Howard T. Wall III

Title: Vice President and Secretary

Dated: February 28, 2008



STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

RIVER PARK HOSPITAL, INC.
501 CORPORATE CENTRE
DRIVE S200
FRANKLIN, TN 370672662 USA

July 16, 2010

Pick Up

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

Control # : 26722 Status: Active
Filing Type: Corporation For-Profit - Domestic

Document Receipt

Receipt # : 221446 Filing Fee: \$20.00
Payment-Check/MO - WALLER LANSDEN DORTCH & DAVIS LLP, Nashville, TN \$20.00

Amendment Type: Articles of Amendment
Filed Date: 07/16/2010 3:40 PM

Image # : 6745-2490

This will acknowledge the filing of the attached articles of amendment with an effective date as indicated above. When corresponding with this office or submitting documents for filing, please refer to the control number given above.

You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee.

Tre Hargett, Secretary of State
Business Services Division

Processed By: Cynthia Dunn

BK/PG:5097/716-717

10023473

CHARTER	
07/19/2010	10:25 AM
BATCH	183051
MTG TAX	0.00
TRN TAX	0.00
REC FEE	5.00
DP FEE	2.00
ARC FEE	0.00
TOTAL	7.00

STATE OF TENNESSEE, WILLIAMSON COUNTY

SADIE WADE
REGISTER OF DEEDS

ARTICLES OF AMENDMENT

TO THE CHARTER OF

RIVER PARK HOSPITAL, INC.

STAT. FILED
2010 JUL 16 PM 3:40
TRE HARGETT
SECRETARY OF STATE
6745-2468

To the Secretary of the State of Tennessee:

In accordance with the provisions of Section 48-60-101 of the Tennessee Business Corporation Act (the "Act"), River Park Hospital, Inc. (the "Corporation"), organized and existing under and by virtue of the provisions of the Act and all amendments thereto, does hereby submit this Amendment to its Charter:

1. The name of the corporation is River Park Hospital, Inc.
2. Section 5 of the Charter is deleted in its entirety and the following is substituted in lieu thereof:

The nature of the business or purposes to be conducted or promoted by the Company is to engage in any and all lawful acts for which corporations may be organized under the Tennessee Business Corporation Act as now or hereafter in force.

3. This amendment was duly authorized and adopted by the Board of Directors and sole shareholder of the Corporation by unanimous written consent action taken effective as of July 15, 2010.

4. This Amendment, which will constitute an amendment to the Charter, is to be effective when filed with the Secretary of State.

IN WITNESS WHEREOF, the undersigned has executed these Articles of Amendment this 16th day of July, 2010.

RIVER PARK HOSPITAL, INC.



Howard T. Wall, III
Vice President and Secretary



STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

River Park Hospital, LLC
TWO CORPORATE CENTRE
STE 200
501 CORPORATE CENTRE DR
FRANKLIN, TN 37067-2662
Control # 26722

April 30, 2012

Effective Date: 04/30/2012

Document Receipt

Receipt # : 748252	Filing Fee:	\$320.00
Payment-Check/MO - WALLER LANSDEN DORTCH & DAVIS LLP, Nashville, TN		\$20.00
Payment-Check/MO - WALLER LANSDEN DORTCH & DAVIS LLP, Nashville, TN		\$300.00

ACKNOWLEDGMENT OF CONVERSION

RIVER PARK HOSPITAL, INC. converted from a **DAVIDSON COUNTY Corporation**
For-Profit to
River Park Hospital, LLC
a DAVIDSON COUNTY Limited Liability Company

This will acknowledge the filing of the attached Articles of Conversion with an effective date as indicated above.

When corresponding with this office or submitting documents for filing, please refer to the control number given above.


Tre Hargett
Secretary of State

Processed By: Carol Dickerson

State of Tennessee



Department of State
Corporate Filings

312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

CERTIFICATE OF CONVERSION

(Domestic For-Profit Corporation into LLC
under TCA §48-21-111)

(For use on or after 7/1/2006)

For Office Use Only

FILED

Pursuant to the provisions of §48-21-111 of the Tennessee Business Corporation Act and §48-249-703 of the Tennessee Revised Limited Liability Company Act, the undersigned hereby submits this certificate of conversion:

1. The name and principal business address of the converting domestic corporation is:
River Park Hospital, Inc.

501 Corporate Centre Drive, Two Corporate Centre, Suite 200

Franklin, Tennessee, Williamson County, Tennessee 37067

2. The converting corporation was formed in Tennessee, its date of formation is: 08/01/1969
(month/day/year)
and its SOS control number (if known) is: 000026722

3. The converting corporation is being converted to a domestic limited liability company, and the name of the domestic limited liability company as set forth in its article of organization is:
River Park Hospital, LLC

4. The plan of conversion is attached to this certificate of conversion and is incorporated herein by reference.

5. The terms and conditions of the conversion have been approved by the unanimous vote of the shareholders; all required approvals of the conversion have been obtained by the converting corporation.

6. The number of members of the limited liability company at the date of conversion is:
1

7. If the conversion is not to be effective upon the filing of the certificate of conversion and articles of organization, then the future effective date and time of the conversion is:

Date: _____ Time: _____

4/30/12
Signature Date

[Signature]
Signature

Chief Executive Officer and President
Signer's Capacity (if other than individual capacity)

Daniel S. Slipkovich
Name (printed or typed)

**PLAN OF CONVERSION
OF
RIVER PARK HOSPITAL, INC.
TO
RIVER PARK HOSPITAL, LLC**

Pursuant to the provisions of Section 48-21-111 of the Tennessee Business Corporation Act (the "Code") and Section 48-249-703 of the Tennessee Revised Limited Liability Company Act, the undersigned, desiring to convert a domestic corporation into a domestic limited liability company, does hereby certify as follows:

1. River Park Hospital, Inc. (the "Corporation"), a Tennessee corporation, shall convert into and continue its existence as River Park Hospital, LLC (the "LLC"), a Tennessee limited liability company (the "Conversion").
2. Upon the filing of the Certificate of Conversion, all of the shares in the Corporation shall be converted into the same proportionate membership interests in the LLC.
3. Upon the filing of the Certificate of Conversion, all of the directors and officers of the Corporation shall become and remain managers and officers, respectively, of the LLC until their respective deaths, resignations, or removal from office.
4. The Articles of Organization of the LLC are attached as Exhibit A hereto.
5. Notification of the approval of the Conversion shall be deemed to be the execution of the operating agreement by the sole member of the LLC, Capella Healthcare, Inc.
6. The Conversion shall be effective as of filing.

[Signature Page Follows]

Dated as of this 30th day of April, 2012.

RIVER PARK HOSPITAL, INC.

By:



Name: Daniel S. Slipkovich

Title: Chief Executive Officer and President

[SIGNATURE PAGE TO PLAN OF CONVERSION OF RIVER PARK HOSPITAL]

000063

ARTICLES OF ORGANIZATION
OF
RIVER PARK HOSPITAL, LLC

FILED

Pursuant to Section 48-249-202 of the Tennessee Revised Limited Liability Company Act, the undersigned, acting as organizer of a limited liability company, hereby adopts the following Articles of Organization:

1. The name of the limited liability company is River Park Hospital, LLC (the "LLC").
2. ^{Ste 2021} ↓ The complete street address of the LLC's initial registered office in Tennessee is 800 S. GAY Street, Knoxville, Knox County, Tennessee 37929. The name of the LLC's initial registered agent at the registered office is CT Corporation System.
3. The LLC will be manager managed.
4. At the date and time of filing of these Articles, there is one (1) member of the LLC.
5. The complete address of the LLC's principal executive office is 501 Corporate Centre Drive, Two Corporate Centre, Suite 200, Franklin, Tennessee, Williamson County, Tennessee 37067.
6. These Articles of Organization shall become effective upon filing.

Dated: April 30, 2012

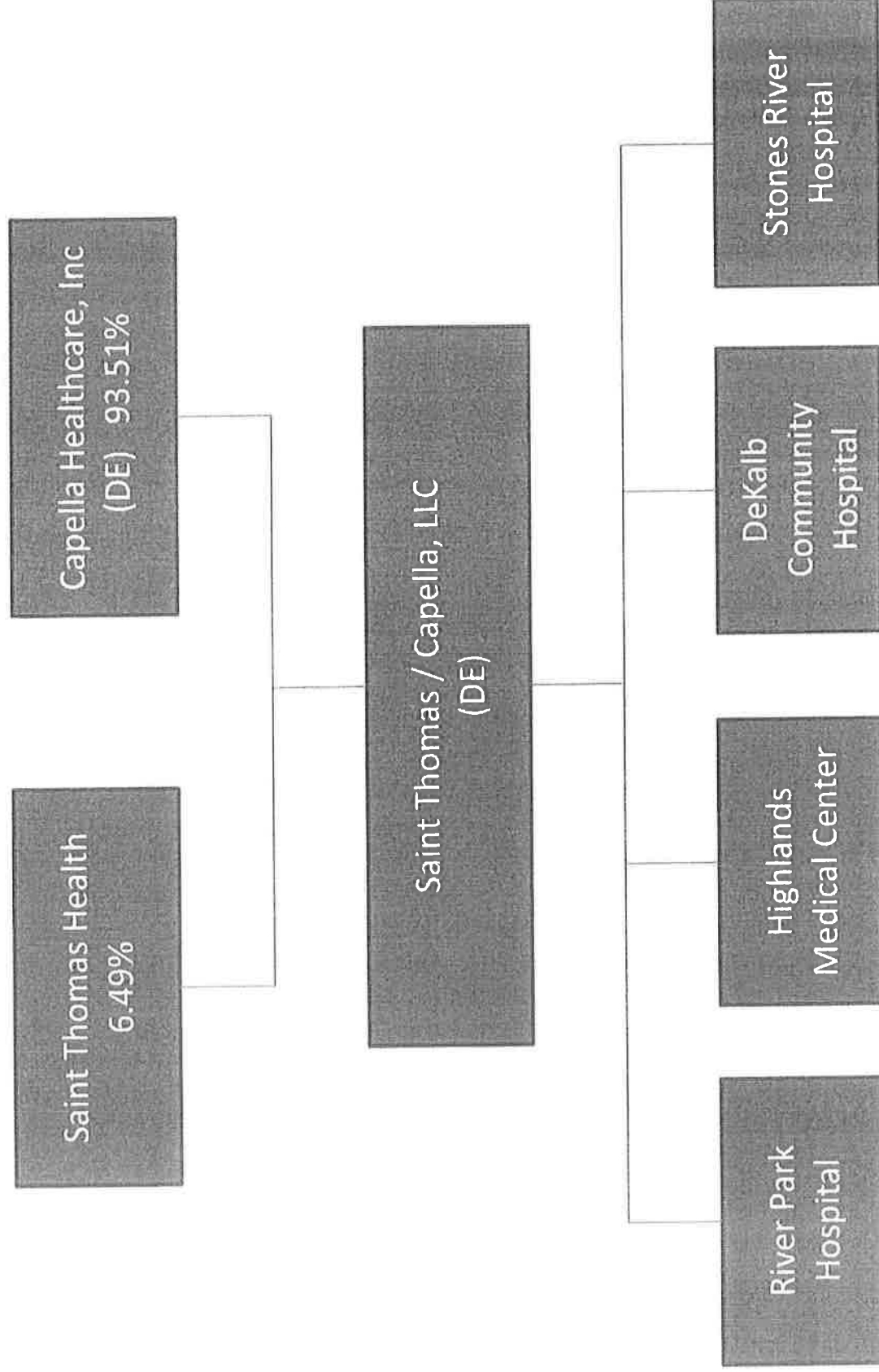

Beth Vessel, Organizer

Tab 2

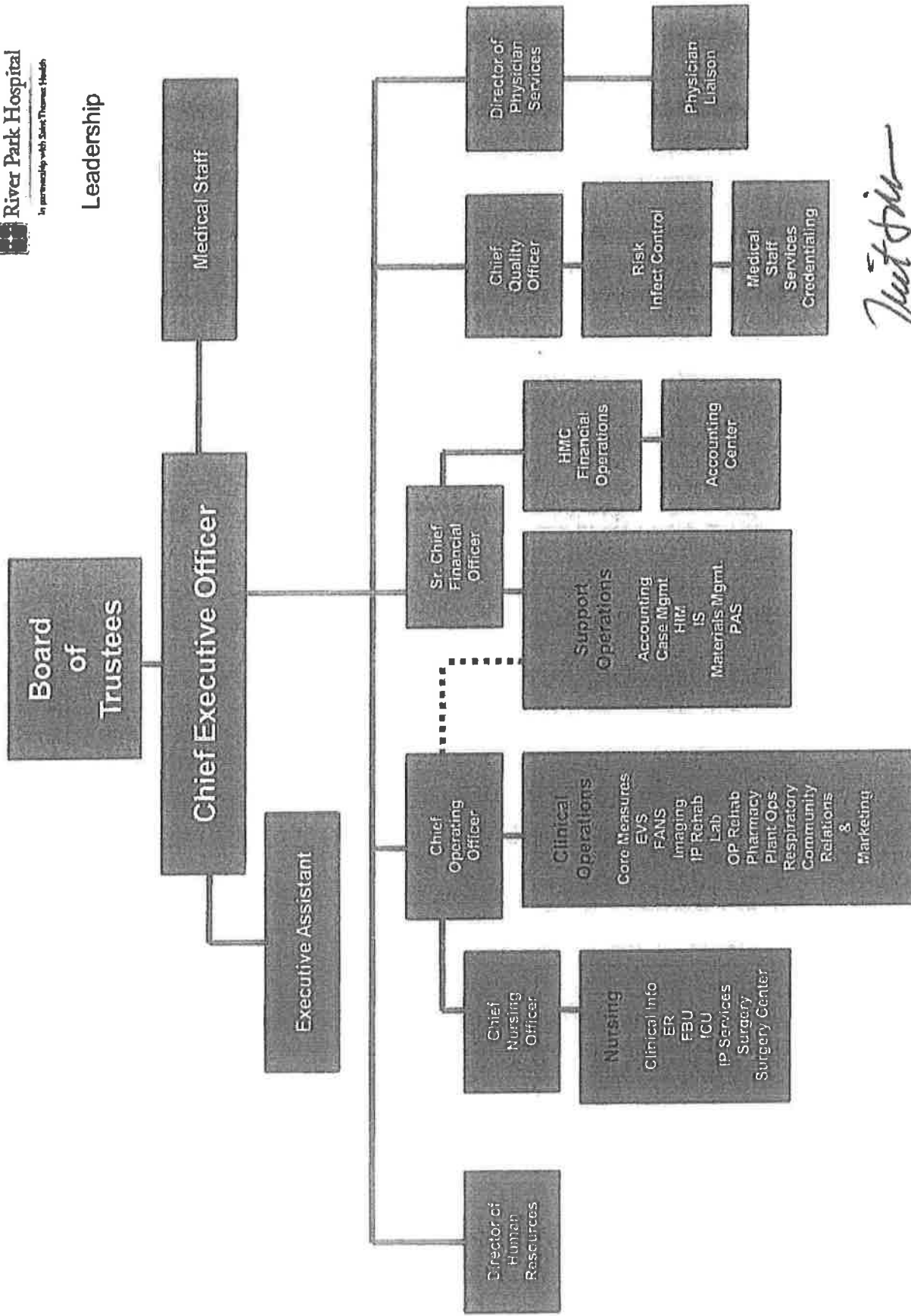
Attachment A, 4

Organizational Chart

Organizational Structure



Leadership



Timothy W. McGill

Timothy W. McGill
Effective February 1, 2014

Tab 3

Attachment A, 4

Board Roster



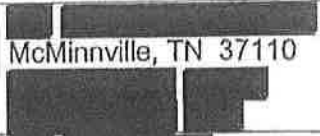
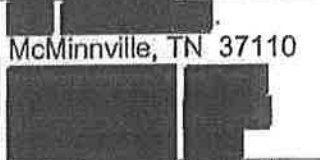
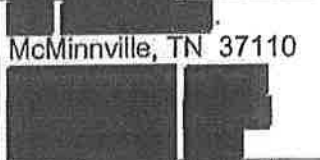
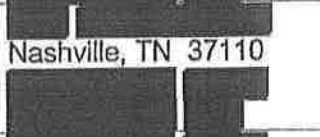
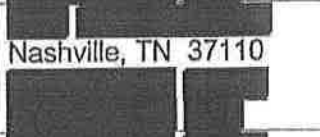


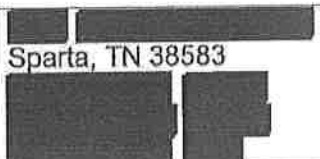
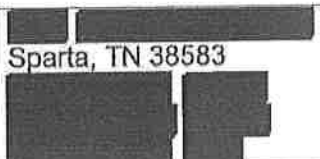

River Park Hospital

In partnership with Saint Thomas Health

1559 Sparta Street
McMinnville, TN 37110
2014 BOARD OF TRUSTEES

	<u>Business</u>	<u>Personal</u>
Brad Brock, MD General Surgery Wife: Melanie (2XL)	1589 Sparta Street #105 McMinnville, TN 37110 815.3636 815.3808 (fax)	[REDACTED] McMinnville, TN 37110 [REDACTED] [REDACTED]
Harry Burck, MD Internal Medicine Wife: Nancy (2XL)	McMinnville Medical Group 1514 Sparta Street McMinnville, TN 37110 931.473.8400 931.473.0620 (fax)	[REDACTED] McMinnville, TN 37110 [REDACTED] [REDACTED]
Bryan Chastain, MD Family Medicine Wife: Theresa (L)	155 Health Way #1 McMinnville, TN 37110 473.5394 473.6636 (fax)	McMinnville, TN 37110 [REDACTED] [REDACTED]
Mike Galligan Attorney – Galligan & Newman Wife: Rhonda (XL)	309 West Main Street McMinnville, TN 37110 473.8405	[REDACTED] [REDACTED] [REDACTED]
Jeff Golden – Board Chair Retired (City Bank) (2XL)		[REDACTED] McMinnville, TN 37110 [REDACTED] [REDACTED]
Dr. Jerry Hale Retired (Warren County School Sup.) Wife: Sherry (2XL)		McMinnville, TN 37110 [REDACTED] [REDACTED] [REDACTED]
Karen Springer Chief Operating Officer Saint Thomas Heart	Saint Thomas Health 102 Woodmont Blvd – Suite 800 Nashville, TN 37205 615.284.6891 karen.springer@stthomas.org	Nashville, TN 37215 [REDACTED] [REDACTED]
Greg Sweeton Retired (Jarden/Oster International) Wife: Sarah (L)		[REDACTED] McMinnville, TN 37110 [REDACTED] [REDACTED]

River Park Employees

Tim McGill Chief Executive Officer Board Secretary Wife: Kathy	River Park Hospital 1559 Sparta Street McMinnville, TN 37110 tim.mcgill@capellahealth.com	 McMinnville, TN 37110 
Joe Mazzo Chief Operating Officer Wife: Amy	River Park Hospital 1559 Sparta Street McMinnville, TN 37110 joseph.mazzo@capellahealth.com	 McMinnville, TN 37110 
Tish Moran Chief Quality Officer	River Park Hospital 1559 Sparta Street McMinnville, TN 37110 tish.moran@capellahealth.com	 Nashville, TN 37110 
Rodney Van Donkelaar Senior Chief Financial Officer	River Park Hospital 1559 Sparta Street McMinnville, TN 37110 rodnev.vandonkelaar@capellahealth.com	 
Dawn Green Executive Assistant	River Park Hospital 1559 Sparta Street McMinnville, TN 37110 dawn.green@capellahealth.com	 Sparta, TN 38583 

Tab 4

Attachment A, 4

Certificate of Corporate Existence



STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

ROBERT M LIMYANSKY
71 VICKERY STREET
ROSWELL, GA 30075

June 26, 2014

Request Type: Certificate of Existence/Authorization
Request #: 0132187

Issuance Date: 06/26/2014
Copies Requested: 1

Document Receipt

Receipt #: 1558775 Filing Fee: \$22.25
Payment-Credit Card - State Payment Center - CC #: 156990722 \$22.25

Regarding: River Park Hospital, LLC
Filing Type: Limited Liability Company - Domestic
Formation/Qualification Date: 08/01/1969
Status: Active
Duration Term: Perpetual
Business County: WILLIAMSON COUNTY

Control #: 26722
Date Formed: 08/01/1969
Formation Locale: TENNESSEE
Inactive Date:

CERTIFICATE OF EXISTENCE

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

River Park Hospital, LLC

- * is a Limited Liability Company duly formed under the law of this State with a date of incorporation and duration as given above;
- * has paid all fees, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;
- * has filed the most recent annual report required with this office;
- * has appointed a registered agent and registered office in this State;
- * has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

Tre Hargett
Secretary of State

Processed By: Cert Web User

Verification #: 007742929

Tab 5

Attachment A, 6

Deed

THIS INSTRUMENT PREPARED BY:
Carla F. Fenswick, Esq.
Waller Lansden Dortch & Davis,
A Professional Limited Liability Company
511 Union Street, Suite 2100
Nashville, Tennessee 37219

STATE OF TENNESSEE
COUNTY OF DAVIDSON

The actual consideration or
value, whichever is greater, for
this transfer is \$0.

Howard H. Patterson
Affiant

Subscribed and sworn to before
me this 25 day of July
2001.

Ronnie H. Watson
Notary Public

My Commission Expires:
May 28, 2003

Terry Smith, Register
Warren County Tennessee
Rec #: 27200 Instrument 27687
Rec'd: 25.00 NBk: 2 Pg 302
State: 0.00 Recorded
Clerk: 0.00 7/27/2001 at 2:45 PM
EDP: 2.00 in Warranty Deed Book
Total: 27.00
318 P 396



ADDRESS OF NEW OWNER: SEND TAX BILL TO: MAP-PARCEL NO.

River Park Hospital, Inc.
c/o HCA Inc.
Real Estate Department
One Park Plaza
Nashville, TN 37203

Same

Map & Parcel:
58 - 91.01

QUITCLAIM DEED

KNOW ALL MEN BY THESE PRESENTS, that for and in consideration of the sum of TEN DOLLARS (\$10.00) cash in hand paid, and other good and valuable consideration, the receipt of which is hereby acknowledged, River Park Hospital Associates, L.P., a Delaware limited partnership ("Grantor"), has bargained and sold, and by these presents does transfer, convey and quitclaim unto River Park Hospital, Inc., a Tennessee corporation ("Grantee"), the representatives, successors and assigns of Grantee, all of its right, title and interest in and to certain real property in Warren County, Tennessee, described as follows, to-wit:

ON LAND DESCRIBED ON EXHIBIT A HERETO:

TO HAVE AND TO HOLD the said real property together with all appurtenances and hereditaments thereunto belonging or in any wise appertaining, to Grantee, the heirs, representatives, successors and assigns of Grantee, forever.

All exhibits referred to herein are attached hereto and incorporated herein by reference. Wherever used, the singular number shall include the plural, the plural the singular, and the use of any gender shall be applicable to all genders.

IN WITNESS WHEREOF, Grantor has caused this Quitclaim Deed to be executed on the 25 day of July, 2001.

GRANTOR:

River Park Hospital Associates, L.P.

By: River Park Hospital, Inc., general partner

By: Howard K. Patterson
Howard K. Patterson
Vice President

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

Personally appeared before me, Howard K. Patterson, the Vice President of River Park Hospital, Inc., a Tennessee corporation, the general partner of River Park Hospital Associates, L.P., a Delaware limited partnership, with whom I am personally acquainted or who produced sufficient identification and who acknowledged that he executed the within instrument for the purposes therein contained on behalf of the limited partnership.

WITNESS my hand, at office, this 25 day of July, 2001.

Ronnie H. Watson
Notary Public

My Commission Expires: May 28, 2003



EXHIBIT A

Description of the Real Property

Tract No. 1: Beginning at an iron stake in the south margin of U.S. Highway 70-S right-of-way, J.E. Johnson Chevrolet Company's northwest corner; thence with south margin of said Highway S $39\frac{1}{4}^{\circ}$ W, 485 feet to an iron stake; thence leaving the Highway and running S 37° E, 740 feet to an iron stake; thence N 47° E, 485 feet to an iron stake; thence N $37\frac{3}{4}^{\circ}$ W, passing the Southwest corner of J. E. Johnson Chevrolet Company tract at 345.6 feet and on in all 800 feet to an iron stake, the point of beginning, containing 8.5 acres, more or less.

Tract No. 2: An easement granted by Warren County, Tennessee, to Robert A. Elkins and wife, Helen Elkins, and Elizabeth B. Elkins, and Scott W. Elkins, trustee, fully described by Deed of Warren County to said persons dated April 22, 1969, and registered in Deed Book No. 158, page No. 350, of the Register's Office of Warren County, Tennessee, and in Deed from Robert A. Elkins and wife, Helen Elkins, to Elizabeth B. Elkins and Scott W. Elkins, trustee, of even date herewith, are registered in Deed Book No. 158, page No. 352, of the Register's Office of Warren County, Tennessee, which easement granted the right to lay, maintain, operate, repair and remove an eight inch sanitary sewer through and over the following described real estate in the First Civil District of Warren County, Tennessee, and known as the Warren County General Hospital, to wit:

A strip of ground bounded by sides 10 feet to the left and 10 feet to the right of the following described center line:

Beginning on an iron stake in the Northwest edge of the right-of-way of U.S. Highway 70-S which beginning point is located as follows, commencing at the Northwest corner of the 8.5 acre tract proposed to be sold by Mrs. Elizabeth B. Elkins and Scott W. Elkins, trustee, thence S $39\frac{1}{4}^{\circ}$ W, 10 feet to an iron stake in the South right-of-way line; thence at right angles Northwest across said Highway 70 feet to a stake in the North right-of-way line which point is now marked by a steel stake and which is the beginning point of the easement conveyed hereunder, thence from said beginning point across the property of Warren County now occupied by it as Warren County General Hospital, Northwestwardly to an existing manhole at the 12 inch sewer line crossing the Warren County property, which manhole is Northwestwardly from the present hospital building.

Tract No. 3: Lying and being in the First Civil District of Warren County, Tennessee, and described as follows:

Beginning on an iron stake in the South margin of Highway 70-S right-of-way, Hospital Corporation of America's Northwest corner, thence running with the South

margin of said Highway 70-S right-of-way S 44° 53' W, 90 feet to an iron stake; thence leaving said highway and running S 38° E, 382.5 feet to an iron stake; thence running N 47° 20' E, 90 feet to an iron stake in the West boundary of Hospital Corporation of America; thence running with the West boundary line of Hospital Corporation of America; thence running with the West boundary line of Hospital Corporation of America approximately N 38° 15' W, 385 feet to the place of beginning, containing .77 acres, more or less.

Grantor acquired said Tracts 1, 2 and 3 by Quitclaim Deed from River Park Hospital, Inc., a Tennessee corporation, of record in Book 255, page 149, Register's Office of Warren County, Tennessee.

Tract No. 4

Land in the First Civil District of Warren County, Tennessee, described as follows:

BEGINNING on a concrete highway right of way marker in the Northwest margin of State Route No. 1 known as the McMinnville and Sparta highway and also in the Northeast margin of the road leading to the hospital known as Warren County Regional Hospital and the State Area Vocational School and running thence North 45 Deg. 40 Min. East, 142.25 feet with the North margin of State Route No. 1 to an iron stake; thence North 42 Deg. 26 Min. East, 156.04 feet with the North margin of State Route No. 1 to an iron stake; thence North 39 Deg. 07 Min. East, 163.28 feet with the North margin of State Route No. 1 to a concrete highway right of way marker; thence North 37 Deg. 29 Min. East, 204.52 feet with the North margin of State Route No. 1 to a concrete highway right of way marker; thence North 38 Deg. 13 Min. East, 108.93 feet with the North margin of State Route No. 1 to a concrete highway right of way marker in the South margin of Cadillac Lane; thence North 40 Deg. 21 Min. West, 513.49 feet with the South margin of Cadillac Lane to a concrete highway right of way marker; thence North 43 Deg. 48 Min. West, 188.78 feet with the South margin of Cadillac Lane to an iron stake at the corner of property now or formerly owned by Warren County; thence South 48 Deg. 15 Min. West, 573.30 feet with the aforesaid Warren County line to an iron stake; thence South 62 Deg. 59 Min. West, 21.11 feet with the aforesaid Warren County line to an iron stake; thence South 84 Deg. 50 Min. West, 89.59 feet with the aforesaid Warren County line to an iron stake; thence South 48 Deg. 30 Min. West, 164.54 feet with the State of Tennessee Area Vocational School line to an iron stake in the Northeast margin of the road leading from State Route No. 1 to the State Area Vocational School; thence South 43 Deg. 21 Min. East, 404.77 feet with the Northeast margin of the State Area Vocational School road to an iron stake; thence North 43 Deg. 15 Min. East, 17.42 feet with the North margin of the State Area Vocational School road to an iron stake; thence South 45 Deg. 21 Min. East, 464.56 feet with the Northeast margin of the State Area Vocational School and Hospital road to the beginning. Containing 14.42 acres, by survey. Said property being more particularly shown on and described according to that certain survey of

Warren County General Hospital, prepared by Earl W. Smith, Tennessee Registered Land Surveyor No. 466, dated June 18, 1986, updated June 24, 1992, which survey is incorporated herein by this reference.

Tract 4 being the same property conveyed to Grantor by deed from National Healthcare of McMinnville, Inc., a Delaware corporation doing business as Warren Regional Hospital, formerly doing business as NHI of McMinnville, Inc. by deed of record in Deed Book 271, Page 60, Register's Office of said County.

Tract No. 5

Beginning at a steel pin in the west line of Cadillac Lane and the north east corner of the Warren County Hospital property and running thence with the north line of the said hospital property at South 48 deg. 30 min. West 577.9 feet to a steel pin in the hospital property line; thence South 63 deg. 10 min. West 21.2 feet to a stake; thence South 86 deg. 19 min. West 88.8 feet to a steel pin in the south line of the property belonging to the State of Tennessee on which is located the State Area Vocational-Technical School; thence with the new south line of the State property North 48 deg. 30 min. East 665.8 feet to a four inch concrete marker in the west right-of-way line of Cadillac Lane and corner of the property belonging to the State of Tennessee; thence with the said right-of-way line, South 43 deg. 31 min. East 60 feet to the beginning corner, containing 37,650 square feet, more or less, as surveyed by Charlie F. Roy (License No. 134) August 10, 1972.

Tract 5 being the same property conveyed to Grantor by deed from Warren County, Tennessee of record in Deed Book 285, page 282, Register's Office for Warren County, Tennessee.

Warranty Deed Book 318 Pg 400

Tab 6

Attachment A, 13

MCO/BHO Participation

<u>MCO/BHO participation List</u>
BCBS ACCESS TN
AETNA HMO
AETNA PPO
AETNA LIMITED BENEFIT PLN
AETNA National Advantage Program
TNCARE AMERIGROUP
BEECH STREET
BEECHSTREET PPO LIMITED
BCBS TN NETWORK P CAPELLA
BLUE CROSS NETWORK PREFERRED
BLUE CROSS TN NETWORK SELECT
BLUE CROSS FEDERAL EMPLOYEE PLAN
TNCARE BLUECARE
TNCARE SELECT
BLUE CROSS OUT OF ST 2
BUYERS HEALTHCARE
BLUEGRASS SINGLESOURCE
BENESIGHT
CIGNA PPO
CIGNA HMO
CIGNA POS FLEXCARE
CIGNA PPO LIMITED BENEFIT
CIGNA STATE OF TN EMPL
BCBS COVER TN
COVENTRY HEALTHCARE
FIRST HEALTH
FIRST HTH LIMITED BENEFIT
GOVT EMPLOYEES HLTH ASSN
GREAT WEST HMO
GREAT WEST POS
GREAT WEST PPO
HEALTHSPRING PLUS
HEALTHSPRING MCARE PLUS
HEALTHSPRING MCARE PPO
LAZARUS HOUSE
HUMANA CHOICECARE
ODOMS TN PRIDE HLTH COST
LIFEPOINT HOSPITALS
MAILHANDLERS
MULTIPLAN
MULTIPLAN CINERGY HEALTH
MULTIPLAN LIMITED BENEFIT
NOVANET PPO
PRIME HEALTH SERVICES
WORK COMP PRIME HEALTH
PHCS

PHCS LIMITED PLAN
PRO AMERICA BEN LOMAND TE
PLUMBERS PIPE LOCAL 572
SIGNATURE HEALTH
HEALTHSPRING TICUA
THREE RIVERS NTWK TRPN
UNITED HEALTHCARE HMO
UNITED HEALTHCARE PPO
UHC GOLDEN RULE
UHC PACIFICARE HLTH SYS
UNITED HEALTHCARE NISSAN
UHC AMERICAN MED SEC
UHC MIDATLANTIC MEDICAL
UHC OXFORD HEALTH PLANS
UHC NEIGHBORHOOD HLTH
UNITED HC RED KAPP
UHC DEFINITY HEALTH
UNITED MEDICAL RESOURCES
UHC OF THE RIVER VALLEY
UHC STATE OF TN EMPLOYEE
TC UHC COMMUNITY PLN RET
TC UHC COMMUNITY PLAN
USA MANAGED CARE
BLUE CROSS SC CAPELLA EMP
PCIP PRE EXISTING COND

Attachment B

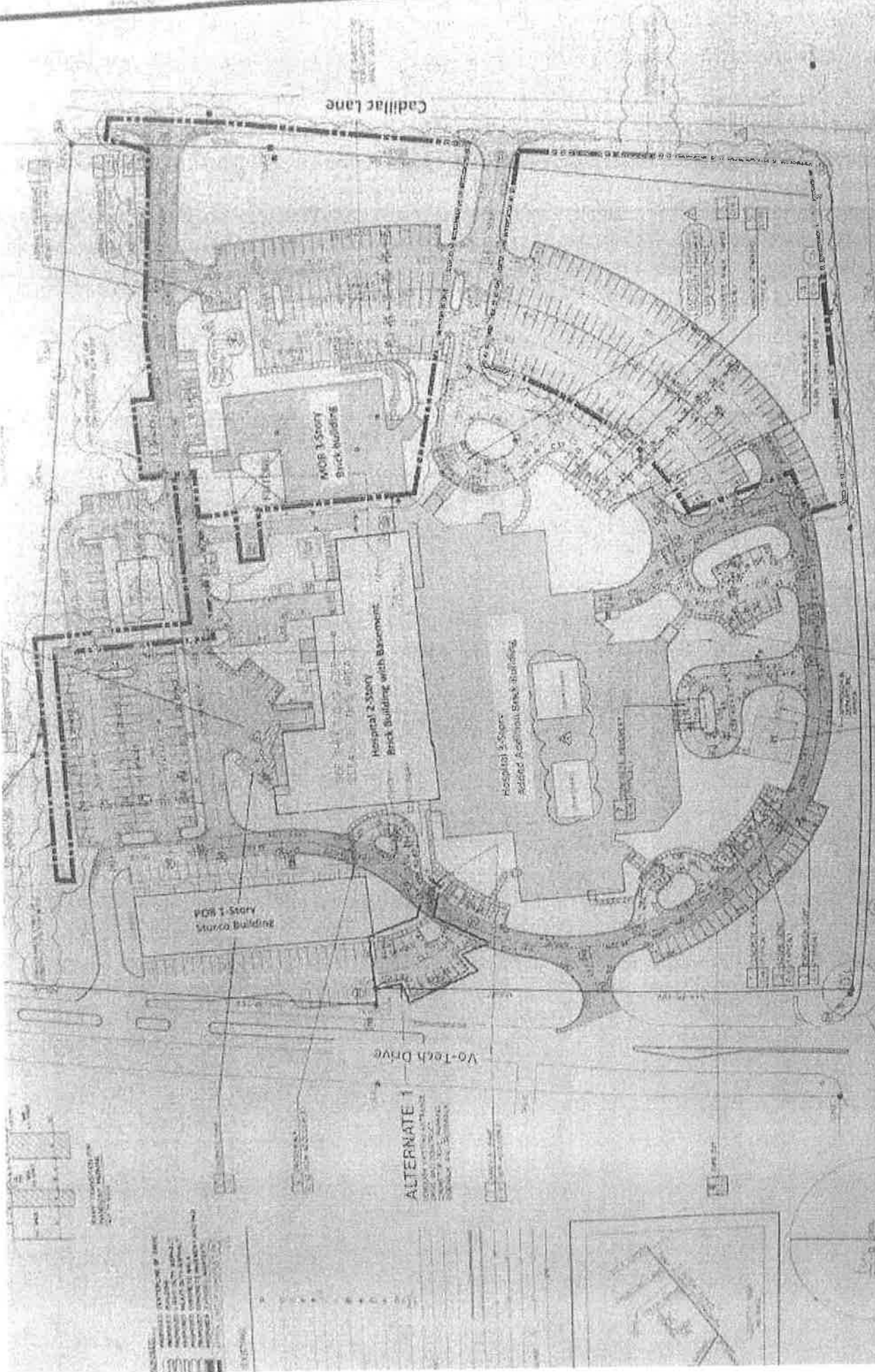
**Plot Plan
Map of Service Area/Access
Floor Plan Schematics**

Tab 7

Attachment B, III.(A)

Plot Plan

SITE LAYOUT



Sparta Highway US 70S

NOT TO SCALE
ALL DIMENSIONS ARE IN FEET
ALL DISTANCES ARE APPROXIMATE
BASED ON FIELD SURVEY DATA

NOT TO SCALE
ALL DIMENSIONS ARE IN FEET
ALL DISTANCES ARE APPROXIMATE
BASED ON FIELD SURVEY DATA

NOT TO SCALE
ALL DIMENSIONS ARE IN FEET
ALL DISTANCES ARE APPROXIMATE
BASED ON FIELD SURVEY DATA

NOT TO SCALE
ALL DIMENSIONS ARE IN FEET
ALL DISTANCES ARE APPROXIMATE
BASED ON FIELD SURVEY DATA

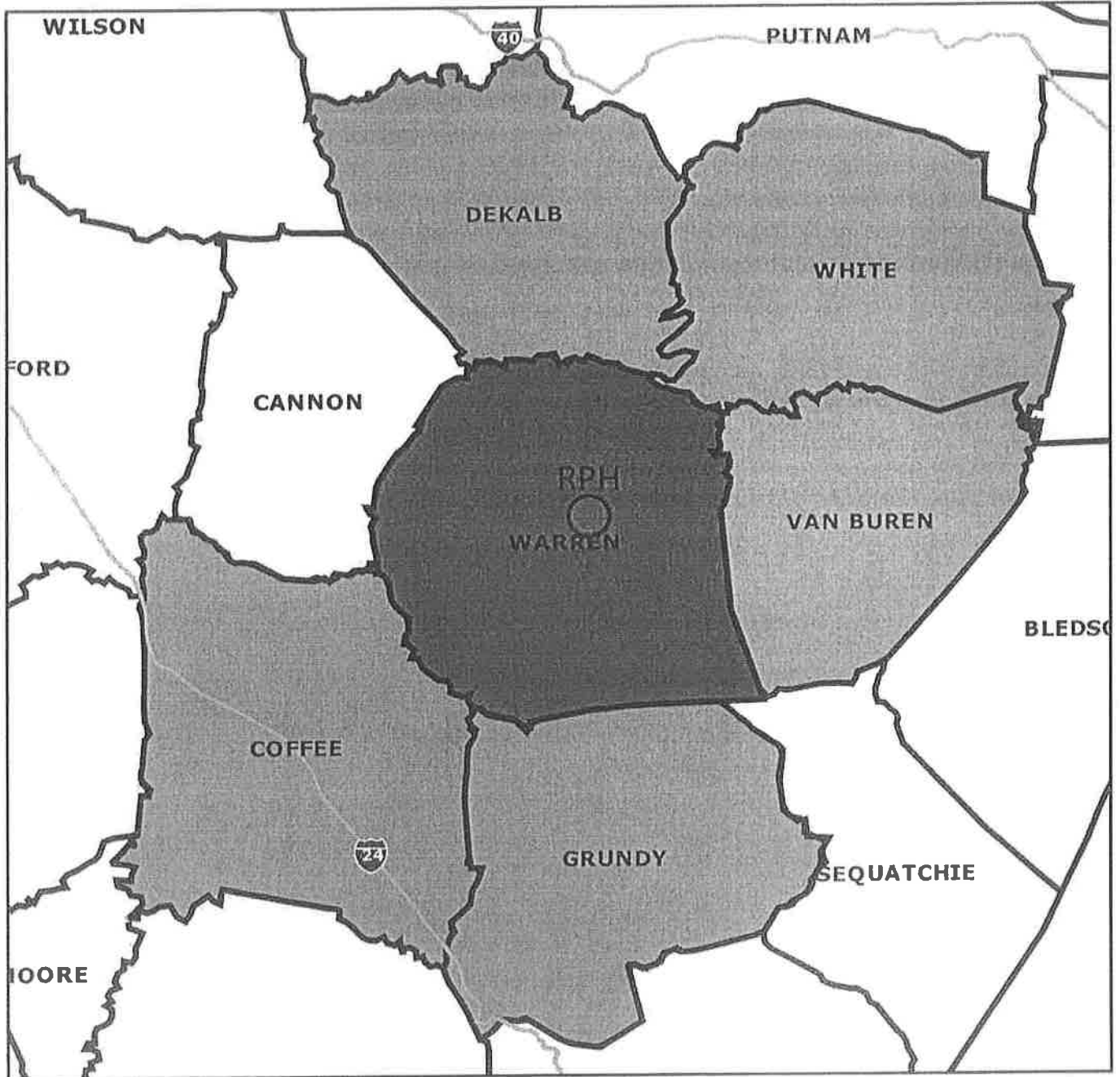
Total Area: 627,887.99 ft²
or 24.332 Acres
Built: 1996

Tab 8

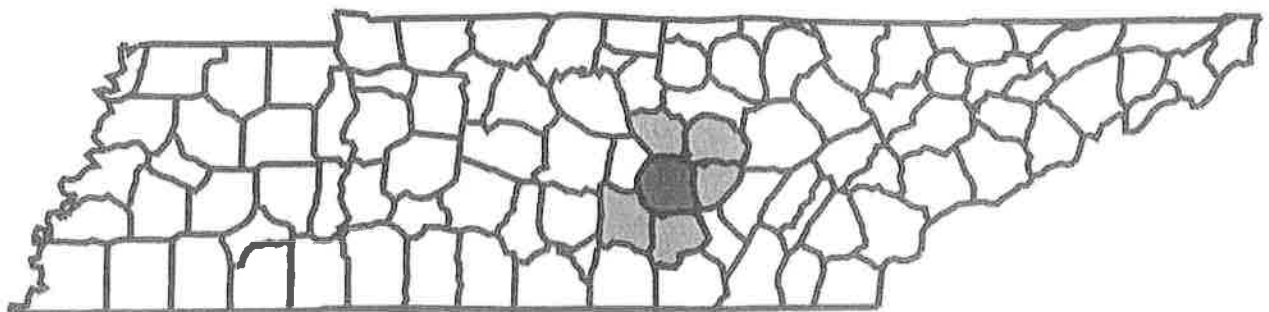
Attachment B, III.(B).1

Map of Service Area/Access

Service Area Map



Primary SA Secondary SA

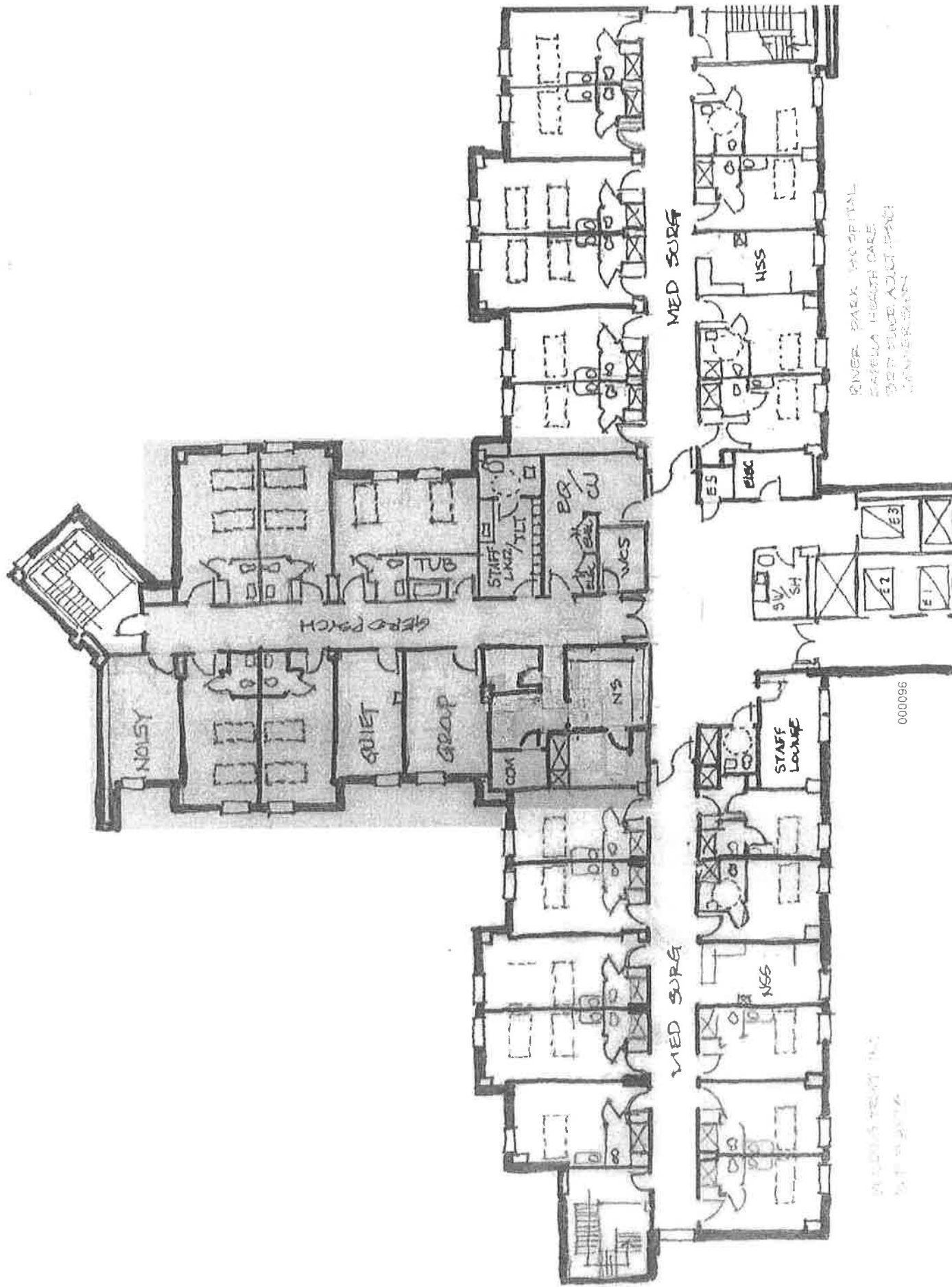


JUL 14 14 04:29

Tab 9

Attachment B, IV

Floor Plan Schematics



RIVER PARK HOSPITAL
 STAFF HEALTH CARE
 1000 ST. LOUIS, MO 63101
 314-241-1000

000096

STAFF HEALTH CARE
 1000 ST. LOUIS, MO 63101
 314-241-1000

Attachment C

**Construction Costs Verification Letter
Verification of Funding
Balance Sheet and Income Statement
Audited Financials
Performance Improvement Plan
Utilization Review Plan
Patient Bill of Rights
The Joint Commission Documentation
Hospital License**

Tab 10

Attachment C
Economic Feasibility - 1

Construction Costs Verification Letter



June 4, 2014

Mr. Tim McGill
CEO
River Park Hospital
1559 Sparta Street
McMinnville, TN 37110

RE: River Park Hospital – 10 Bed Geropsych Conversion

Mr. McGill:

This letter is being issued as verification that the submitted estimate of cost for the proposed psychiatric bed conversion project at River Park Hospital with 5,066 SF is reasonable. The construction estimate of \$975,000 (\$192.46 / sq. ft.) is based on comparative estimates of similar construction and adjusted local trades.

I attest that the design and construction information submitted is consistent with the design and cost of similar facilities in the region. The physical environment will conform to the applicable federal, state, and local construction codes, standards, manufacturers' specifications and licensing agencies requirements, including the current 2010 FGI Guidelines for Design and Construction of Health Care Facilities.

We hope this meets with your approval and stand ready to answer any questions that you may have. As always, we look forward to assisting in the development of this project. Please feel free to call me with any questions, clarifications, or comments.

Sincerely,

BUILDINGTRUST, INC.



Kenny Beam
President

Tab 11

Attachment C
Economic Feasibility - 2

Verification of Funding



501 Corporate Centre Drive, Suite 200
Franklin, TN 37067-2662

phone 615.764.3000 | fax 615.764.3030
CapellaHealthcare.com

May 28, 2014

Melanie M. Hill, Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

RE: Certificate of Need Application
River Park Hospital Adult Geriatric Behavioral Health Unit

Dear Ms. Hill:

River Park Hospital is applying for a Certificate of Need for a 10-bed Geriatric Behavioral Health Unit. The estimated project cost is \$1.1m.

As Vice President of Finance, I am writing to confirm that River Park Hospital has sufficient resources to fund the capital cost required to implement this project.

Thank you for your attention to this matter.

Sincerely,

Christina Patterson
VP, Finance

Tab 12

Attachment C
Economic Feasibility - 10

Balance Sheet and Income Statement

SCHEDULE E - FINANCIAL DATA (continued)*

State ID 89234

A. CHARGES (continued)

7. Other Operating Revenue

a) Tax appropriations	\$0
b) State and Local government contributions:	
1) Amount designated to offset indigent care	\$0
2) Essential Access Hospital (EAH) payments	\$236,672
3) Critical Access Hospital (CAH) payments	\$0
4) Amount used for other	\$0
5) Total	\$236,672
c) Other contributions:	
1) Amount designated to offset indigent care	\$0
2) Amount used for other	\$0
3) Total	\$0
d) Other (include cafeteria, gift shop, etc.)	\$180,121
e) Total other operating revenue	\$416,793
(A7a + A7b5 + A7c3 + A7d)	

8. Nonoperating Revenue (No negative numbers! Losses or expenses should be reported in B2g.)

a) Contributions	\$0
b) Grants	\$20,000
c) Interest Income	\$581
d) Other	\$324,892
e) Total nonoperating revenue	\$345,473
(add A8a through A8d)	
f) TOTAL REVENUE	\$50,089,171
(Net A4e + A7e + A8e)	

B. EXPENSES (for the reporting period only; round to the nearest dollar)

1. Payroll Expenses for all categories of personnel specified below; (see definitions page)	
a) Physicians and dentists (include only salaries)	\$0
b) Medical and dental residents (include medical and dental interns)	\$0
c) Trainees (medical technology, x-ray therapy, administrative, and so forth)	\$0
d) Registered and licensed practical nurses	\$5,077,476
e) All other personnel	\$9,682,698
f) Total payroll expenses	\$14,760,174
(add B1a through B1e)	
2. Nonpayroll Expenses	
a) Employee benefits (social security, group insurance, retirement benefits)	\$3,949,293
b) Professional fees (medical, dental, legal, auditing, consultant and so forth)	\$2,820,501
c) Contracted nursing services (include staff from nursing registries, service contracts, and temporary help agencies)	\$149,434
d) Depreciation expense	\$2,437,320
e) Interest expense	\$3,789,876
f) Energy expense	\$826,849
g) All other expenses (supplies, purchased services, nonoperating expenses, and so forth)	\$15,942,562
h) Total nonpayroll expenses (add B2a through B2g)	\$29,915,835
i) TOTAL EXPENSES (add B1f + B2h)	\$44,676,009

3. Are system overhead/management fees included in your expenses?

If yes, specify amount ☒ YES ☐ NO \$734,330

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C. CURRENT ASSETS

1. Current Assets is defined as the value of cash, accounts receivable, inventories, marketable securities and other assets that could be converted to cash in less than 1 year.

What were your current assets on the last day of your reporting period (specified in Schedule A7 on page 2)? \$6,694,052

Net receivables are defined as the collectibles as of the last day of your reporting period, whether or not they are currently due.

2. What were your net receivables on the last day of your reporting period? \$6,048,859

D. FIXED ASSETS recorded on the balance sheet at the end of the reporting period (include actual or estimated value of plant/equipment that is leased).

1. Gross plant and equipment assets (including land, building, and equipment) \$43,897,129

2. LESS: Deduction for accumulated depreciation \$19,641,692

3. NET FIXED plant and equipment assets (D.1. Less D.2.; if zero please explain on separate sheet) \$24,255,437

E. OTHER ASSETS recorded on the balance sheet at the end of the reporting period (include assets not included above as current or fixed assets).

What were your other assets on the last day of your reporting period (specified in Schedule A7 on page 2)? \$752,168

F. TOTAL ASSETS

Total Assets is the sum of current assets, fixed assets and other assets (C.1. +D.3. +E.).

What were your total assets on the last day of your reporting period (specified in Schedule A7 on page 2)? \$31,701,657

G. CURRENT LIABILITIES

Current liabilities is defined as the amount owed for salaries, interest, accounts payable, and other debts due within one (1) year. What were your current liabilities on the last day of your reporting period? \$5,209,449

H. LONG TERM LIABILITIES

1. Long Term Liabilities is defined as the amount owed for leases, bond repayment and other items due after one (1) year. What were your long term liabilities on the last day of your reporting period? \$782,568

2. Long-Term Debt is defined as the value of obligations of over 1 year that require interest to be paid. What was your long term debt on the last day of your reporting period? \$7,916,181

I. OTHER LIABILITIES

Other liabilities includes those liabilities not reported as current (item G.) or long term (item H.1.).

What were your total liabilities on the last day of your reporting period (specified in Schedule A7 on page 2)? -\$446,325

J. CAPITAL ACCOUNT

Capital Account includes Fund Balance or Stockholder's Equity and all general, specific purpose, restricted or unrestricted funds. The Capital Account is the excess of assets over its liabilities.

What was your capital account on the last day of your reporting period? \$26,155,965

Note: Total Assets should equal Liabilities plus Capital Account (i.e. item F.=G.+H.1.+I.+J.).

K. 1. Federal Income Tax:

\$0

2. Local Property Taxes Paid During the Reporting Period:

a) Taxes on the Inpatient Facility \$425,844

b) Taxes on all Other Property \$25,812

3. Other Local, State, or Federal Taxes:
(exclude sales tax)

\$165,269

L. Does your hospital bill include charges incurred for the following professional services?

Radiology - YES ☐ NO ☐ Pathology - YES ☐ NO ☐ Anesthesiology - YES ☐ NO ☐ Other - Specify _____

SCHEDULE E - FINANCIAL DATA (continued)*

State ID 89234

M. TennCare Utilization and Revenue:

1. Inpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF ADMISSIONS	NUMBER OF PATIENT DAYS	GROSS REVENUE	NET REVENUE
United Health Care Community Plan	350	951	\$7,790,518	\$813,804
Amerigroup	244	636	\$5,719,254	\$781,439
Blue Care	16	39	\$373,738	\$31,805
TennCare Select	15	39	\$345,081	\$22,890
TennCare, MCO (Not Specified)	1	1	\$12,724	\$0
Total MCO	626	1,666	\$14,241,315	\$1,649,938

2. Outpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF PATIENTS	NUMBER OF VISITS	GROSS REVENUE	NET REVENUE
United Health Care Community Plan	9,082	9,803	\$25,497,632	\$2,591,118
Amerigroup	5,379	6,139	\$15,602,561	\$1,683,737
Blue Care	320	345	\$954,503	\$91,924
TennCare Select	328	361	\$943,609	\$87,118
TennCare, MCO (Not Specified)	12	12	\$18,242	\$503
Total MCO	15,121	16,660	\$43,016,547	\$4,454,400

Tab 13

Attachment C
Economic Feasibility - 10

Audited Financials

**UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549**

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES
EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2013

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES
EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 333-175188

Capella Healthcare, Inc.

(Exact name of registrant as specified in its charter)

Delaware

(State or other jurisdiction of
incorporation or organization)

20-2767829

(I.R.S. Employer
Identification No.)

501 Corporate Centre Drive, Suite 200

Franklin, Tennessee

(Address of principal executive offices)

37067

(Zip Code)

(615) 764-3000

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act: None

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☐ No ☒

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☒ No ☐

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☐ No ☒

000112

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act:

Large accelerated filer ☐

Accelerated filer ☐

Non-accelerated filer ☒ (Do not check if a smaller reporting company)

Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒

None of the registrant's common stock is held by non-affiliates.

As of March 11, 2014, the number of outstanding shares of the registrant's common stock was 100.

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PART I

Item 1. Business.

Company Overview

Capella Healthcare, Inc., a Delaware corporation which was formed on April 15, 2005, is a provider of general and specialized acute care, outpatient and other medically necessary services in primarily non-urban communities. Unless otherwise noted or unless the context requires otherwise, the term “Capella” refers to Capella Healthcare, Inc. and the terms the “Company,” “we,” “us” and “our” refer to Capella and its consolidated subsidiaries. As of December 31, 2013, as part of continuing operations, we operated 11 acute care hospitals (ten of which we own and one of which we lease pursuant to a long-term lease) comprised of 1,504 licensed beds in six states.

Our hospitals offer a broad range of general acute care services, including, but not limited to, internal medicine, general surgery, cardiology, oncology, orthopedics, women’s services, neurology and emergency services. In addition, our facilities also offer other specialized and ancillary services, including, for example, psychiatric, diagnostic, rehabilitation, home health and outpatient surgery.

In addition to providing capital resources, we make available a variety of management services and expertise to affiliated healthcare facilities. These services include ethics and compliance, group purchasing, accounting, financial, clinical systems, resource management, governmental reimbursement, information systems, legal, personnel management, internal audit and access to managed care networks.

We generated \$651.4 million, \$718.2 million and \$722.3 million in revenue from continuing operations, net of the provision for bad debts, for the years ended December 31, 2011, 2012, and 2013, respectively.

Our mission is to provide high quality healthcare in the communities we serve and to provide services in an affordable and accessible manner in a patient-friendly environment. We also believe in partnering with communities to build strong local healthcare systems, especially communities that are either growing or are underserved. We invest our financial and operational resources to establish and support services that meet the needs of our communities. We seek to achieve our objectives by providing exceptional quality care to our patients, establishing strong local management teams, physician leadership groups and hospital boards, developing deep physician and employee relationships and working closely with our communities.

Availability of Information

The Company’s internet website address is www.capellahealth.com. The Company currently makes available free of charge on its website under “Investor Relations — SEC Filings” its annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and amendments to those reports filed or furnished as soon as reasonably practicable after the Company electronically files such materials with, or furnishes them to, the United States Securities and Exchange Commission (“SEC”).

Our Business Strategy

The key elements of our business strategy are:

Enhancing Quality of Care and Service Excellence

We place significant emphasis on consistently providing high quality patient care and service excellence. We seek to achieve this by continuously enhancing our programs and protocols through targeted investments in our employees, physicians, systems and strategic growth initiatives. We believe value-based purchasing initiatives of both governmental and private payors, such as linking payment for healthcare services to performance on objective quality measures, increasingly will become key drivers of financial performance. Examples of these initiatives include denying payment for avoidable hospital re-admissions and bundling payments for acute care services with physician or post-acute services. We believe our continued strategic investments to improve patient care excellence will prepare us to face the challenges and capitalize on the opportunities relating to the ever-changing, pay-for-performance environment. Some of our strategic initiatives in quality and service excellence include:

- *Emergency Rooms.* We embarked on a multi-year strategy to enhance quality and improve operating efficiencies in our emergency rooms. This strategy involves implementing process improvement initiatives, which are designed to improve patient experiences through more efficient utilization of resources.
- *Local Physician Leadership Groups, or LPLGs.* Our LPLGs are comprised of six to eight physician leaders and our hospital chief executive officer, or hospital CEO, in each of our markets. The groups (i) provide ongoing dialogue with hospital administration; (ii) help develop key clinical strategic initiatives for the hospital; and (iii) promote patient care excellence.

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- *Physician Advisory Group, or PAG.* Our PAG is comprised of physician leaders across the Company. The group (i) provides clinical review and guidance related to information system design, build-out and workflow; (ii) advises us on physician communication and education; and (iii) identifies opportunities where technology can be used to improve clinical processes and outcomes.
- *National Physician Leadership Group, or NPLG.* Our NPLG is comprised of one member of each LPLG and Capella's executive management team. The group (i) receives updates on the Company's corporate strategy and vision; (ii) discusses quality of care issues and goals; (iii) promotes networking among Capella-affiliated physicians; (iv) offers advice on special projects where front line physician input is critical; and (v) allows members of the medical staff to have direct communication with members of Capella's executive management team.
- *Chief Medical Officer, or CMO.* Our corporate CMO is responsible for facilitating the work of our NPLG, ensuring that physician leaders from across the Company are continuously involved in shaping our vision and future strategies. The CMO is also responsible for providing leadership for the quality and service excellence initiatives at each of our hospitals as well as for on-going communication with medical staff members. The Company's CMO, Dr. Erik Swensson, retired effective February 28, 2014. The Company currently is conducting a nationwide search to fill the position.
- *Training and Education.* We provide a customized on-line learning center comprised of approximately 3,000 clinically based courses to all our staff. Our corporate office develops and implements a work plan for each of our hospitals based upon their specific needs. Each hospital's Chief Quality Officer, or CQO, and Chief Nursing Officer, or CNO, in turn, develops individual educational work plans for each staff member at their facility. Usage of the Capella Learning Center is monitored by the corporate office and is reported to Capella's executive management team. We also work with an independent consulting group to provide training in the areas of improving patient care processes as well as employee, physician and patient satisfaction. We believe this is a critical element in emphasizing our philosophy that, if our employees and physicians enjoy where they work, and if they are intellectually stimulated, they will improve patient care excellence. We survey our physicians and our employees on an annual basis to identify objectives for quality and satisfaction improvement.
- *Compensation.* We base the incentive compensation for our hospital administrative teams in significant part on achieving key individual and facility quality and service metrics, such as performance on patient satisfaction surveys and other core measurements.

Investing in Technology to Improve Patient Care

We believe that investment in technology drives improvement in clinical outcomes and quality of patient care. The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), which was enacted into law on February 17, 2009 as part of the American Recovery and Reinvestment Act of 2009 (the "ARRA"), includes provisions designed to increase the use of computerized physician order entry at hospitals and the use of electronic health records ("EHR") by both physicians and hospitals. We believe that these systems improve quality, safety and clinical outcomes, and we intend to comply with all EHR meaningful use requirements of the HITECH Act.

Continued Physician Engagement and Alignment Initiatives

Our ability to meet the medical care needs of our communities and enhance and expand our services is highly dependent on our physician engagement strategies. We have a comprehensive recruiting program that is directed at the local level by our hospital CEOs and Boards of Trustees. We supplement our local teams with several third party recruiting firms to assist in identifying candidates that match the profile of our physician needs. We maintain a flexible approach to aligning our goals with our physician partners, including our willingness to recruit physicians through multi-year employment and/or income guarantee arrangements and to enter into other collaborative arrangements. As discussed above, our executive management team includes a CMO to assume leadership responsibility for facilitating the work of our NPLG in an effort to keep physician leaders across the Company continuously involved in shaping the Company's vision and future strategies. In addition, we believe physicians are attracted to our hospitals because of several factors, including:

- our commitment to patient care excellence;

- our willingness to deploy strategic capital to improve the delivery of care;
- our focus on employing and developing high quality nursing and support staff; and
- our integration into, and support of, the communities we serve.

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Identifying and Establishing Strong Local Market Leadership

We empower our individual hospital management teams to develop comprehensive strategic plans that position their respective hospitals to meet the healthcare needs of the communities we serve. In addition to strong corporate oversight and resources, each of our local leadership teams is supported by a local Board of Trustees and a LPLG. The Board of Trustees is comprised of physicians and community leaders as well as the hospital CEO. We believe local community leaders are an important resource for our hospital CEOs to insure that we are being responsive to the needs of the communities we serve. Our LPLGs are typically comprised of local physician leaders as well as members of our hospital's administration. These groups ensure that we are providing patient care excellence, offering the appropriate medical services, maintaining high quality employees and recruiting the best physicians to our medical staff. Our corporate office provides continuous operational, financial and human resources support to our local teams and has designed programs that allow us to share best practices across our entire portfolio of facilities.

Expanding the Services We Provide

Each year, we conduct in-depth strategic reviews of the major service lines at each of our facilities as well as market demand for additional services. We leverage our local market knowledge, together with input and guidance from our local physician and community leaders, to prioritize the healthcare services that our communities are seeking. We then initiate an assessment and develop an investment plan that supports the expansion of the appropriate services. Focus areas include:

- expanding specialty medical services, such as medical and radiation oncology, cardiovascular, orthopedic, neurology, behavioral health and women's services;
- initiating and expanding outpatient services;
- investing in medical equipment and technology to support our service lines;
- improving our efficiency to deliver better quality care in our emergency rooms; and
- enhancing patient, physician and employee satisfaction.

We have engaged consultants and are working with our hospital CEOs to identify trends in service lines and areas for future expansion of services. We remain motivated to invest in our facilities in order to increase the quality and scope of services we provide, meet the needs of our communities and establish a strong reputation so that we may continue to recruit leading physicians, and become the healthcare provider of choice in our communities.

Pursuing Acquisitions and Strategic Relationships

We believe we will continue to have opportunities to pursue acquisitions of hospitals and other healthcare facilities both in existing and new markets. We will pursue a disciplined acquisition strategy in markets where we believe we can have the greatest impact on operational and quality performance of the acquired facility. We will continue to target acute care hospitals and ancillary facilities in attractive, primarily non-urban markets with populations generally greater than 35,000. We have focused criteria that cover multiple aspects of a new facility and include demographics, patient care results, operational improvement, financial improvement and cultural alignment. We perform a significant amount of due diligence on each facility we intend to acquire to ensure that our criteria are met.

We also anticipate we will have opportunities to pursue selective acquisitions or otherwise develop complementary ancillary businesses in the markets we currently serve. We have placed a significant emphasis on pursuing such strategic in-market transactions that support our ability to expand our community service offerings. These investments can include, but are not limited to: ambulatory surgery centers, outpatient diagnostic imaging centers, free-standing clinical laboratories, home healthcare and urgent or primary care centers. Our criteria for in-market strategic investments are similar to our criteria for external acquisitions, including focusing on outpatient ancillary centers where we can improve operations.

Delivering Strong Financial Performance

We seek to maintain disciplined financial policies aimed at growing revenue, improving margins and generating free cash flow. We continue to focus on ways in which we can increase revenue from our existing facilities, including continued

investments to expand services, continued physician recruitment to meet our communities' needs and negotiating favorable managed care contracts. We are also focused on capitalizing on several operational efficiencies to improve our margins and free cash flow, including:

- continued focus on revenue cycle management and collections;
- disciplined deployment of capital across our portfolio;
- encouragement and motivation of our physicians and medical staff to adhere to our established protocols related to medical supplies utilization;
- infrastructure build-out to support our growing physician clinic operations;
- implementation of appropriate staffing tools and continued reduction of contract labor; and
- leveraged technical expertise through use of our corporate resources.

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Our Hospital Operations

Acute Care Services

Our hospitals typically provide the full range of services commonly available in acute care hospitals, such as internal medicine, general surgery, cardiology, oncology, neurosurgery, orthopedics, women's services, diagnostic and emergency services, as well as select tertiary services, such as open-heart surgery. Our hospitals also generally provide outpatient and ancillary healthcare services such as outpatient surgery, laboratory, radiology, respiratory therapy and physical therapy. We also provide outpatient services at our imaging centers and ambulatory surgery centers. Certain of our hospitals have a limited number of psychiatric, skilled nursing and rehabilitation beds.

Management and Oversight

Our executive management team has extensive experience in operating multi-facility hospital networks and plays a vital role in the strategic planning for our facilities. A hospital's local management team is generally composed of a chief executive officer, chief operating officer, chief financial officer, chief nursing officer and chief quality officer. Local management teams, in consultation with their LPLG and the hospital's Board of Trustees and our corporate staff, develop annual operating plans setting forth growth strategies through the expansion of current services, implementation of new services and the recruitment and retention of physicians in each community, as well as plans to improve operating efficiencies and reduce costs. We believe that the ability of each local management team to identify and meet the needs of our patients, medical staffs and the community as a whole is critical to the success of our hospitals. We base the compensation for each local management team in part on its ability to achieve the goals set forth in the annual operating plan, including quality of care, patient satisfaction and financial measures.

The Board of Trustees at each hospital, consisting of local community leaders, members of the medical staff and the hospital CEO, advises the local management teams and helps develop the strategic operating plan for their hospital. In addition, it plays a key role in providing the patient care excellence that Capella demands. Members of each Board of Trustees are identified and recommended by our local management teams. The Boards of Trustees oversees policies concerning medical, professional and ethical practices, monitor these practices and ensure that they conform to our high standards. We maintain company-wide compliance and quality assurance programs and use patient care evaluations and other assessment methods to support and monitor quality of care standards and to meet accreditation and regulatory requirements.

Each hospital has a LPLG made up of key physicians and members of the hospital's administrative team. The Chairman of each group serves on Capella's NPLG. The mission of the LPLG is to provide ongoing dialogue between hospital administration and members of the medical staff primarily in the areas of operations, quality patient care, employee satisfaction and community relations.

We also provide support to the local management teams through our corporate resources in areas such as revenue cycle, business office, legal, managed care, clinical efficiency, physician services and other administrative functions. These resources allow for sharing best practices and standardization of policies and processes among all of our hospitals.

Attracting Patients

We believe that the most important factors affecting a patient's choice in hospitals are the reputation of the hospital, the availability and expertise of physicians and nurses and the location and convenience of the hospital. Other factors that affect utilization include local demographics and population growth, local economic conditions and the hospital's success in contracting with a wide range of local payors.

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Outpatient Services

The healthcare industry has experienced an accelerated shift during recent years from inpatient services to outpatient services as Medicare, Medicaid and managed care payors have sought to reduce costs by shifting lower-acuity cases to an outpatient setting. Advances in medical equipment technology and pharmacology also have supported the shift to outpatient utilization, which has resulted in an increase in the acuity of inpatient admissions. However, we expect inpatient admission use rates to moderate over the long term as the baby boomer population reaches ages where inpatient admissions become more prevalent. We have responded to the shift to outpatient services through expanding service offerings and increasing the throughput and convenience of our emergency departments, outpatient surgery facilities and other ancillary units in our hospitals. We also own minority interests in a surgery center in the Muskogee, Oklahoma service area. We continually upgrade our resources, including procuring excellent physicians and nursing staff and utilizing technologically advanced equipment, to support our comprehensive service offerings to capture inpatient volumes from the baby boomers.

Sources of Revenue

General

Revenue before the provision for bad debts at our hospitals consists mostly of fixed payments from discounted sources, including Medicare, Medicaid and managed care organizations. Reimbursement for Medicare and Medicaid services are often fixed regardless of the cost incurred or the level of services provided. Similarly, various managed care companies with which we contract reimburse providers on a fixed payment basis regardless of the costs incurred or the level of services provided. Revenue before the provision for bad debts is reported net of discounts and contractual adjustments. Contractual adjustments principally result from differences between the hospitals' established charges and payment rates under Medicare, Medicaid and various managed care plans. Additionally, discounts and contractual adjustments result from our uninsured discount and charity care programs.

We receive payment for patient services primarily from:

- the federal government, primarily under the Medicare program;
- state Medicaid programs, including managed Medicaid plans;
- managed care payors, including health maintenance organizations, preferred provider organizations and managed Medicare plans; and
- individual patients and private insurers.

The table below presents the approximate percentage of revenue before the provision for bad debts we received from the following sources for the periods indicated :

	Year Ended December 31,		
	2011	2012(2)	2013
Medicare(1)	39.2%	39.2%	38.1%
Medicaid(1)	12.8	15.3	14.4
Managed Care and other	37.9	35.3	36.0
Self-Pay	10.1	10.2	11.5
Total	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>

- (1) Includes revenue before the provision for bad debts received under managed Medicare or managed Medicaid programs.
- (2) The increase in Medicaid revenue for 2012 is due primarily to the Oklahoma Supplemental Hospital Offset Payment Program, or SHOPP. SHOPP increased Medicaid revenue by approximately \$21.5 million in fiscal 2012.

Medicare is a federal program that provides hospital and medical insurance benefits to persons age 65 and over, some disabled persons and persons with Lou Gehrig's Disease and end-stage renal disease. All of our hospitals are certified as providers of Medicare services. Under the Medicare program, acute care hospitals receive reimbursement under a prospective payment system that generally pays fixed rates for inpatient and outpatient hospital services. Currently, certain types of facilities are exempt or partially exempt from the prospective payment system methodology, including children's hospitals,

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cancer hospitals and critical access hospitals. Hospitals and units exempt from the prospective payment system are reimbursed on a reasonable cost-based system, subject to cost limits.

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Our hospitals offer discounts from established charges to managed care plans if they are large group purchasers of healthcare services. Additionally, we offer discounts to all uninsured patients receiving healthcare services who do not qualify for assistance under state Medicaid, other federal or state assistance plans or charity care. These discount programs generally limit our ability to increase revenue before the provision for bad debts in response to increasing costs. Patients generally are not responsible for any difference between established hospital charges and amounts reimbursed for such services under Medicare, Medicaid, health maintenance organizations, preferred provider organizations or private insurance plans. Patients generally are responsible for services not covered by these plans, along with exclusions, deductibles or co-insurance features of their coverage. Collecting amounts due from patients is more difficult than collecting from governmental programs, managed care plans or private insurers. Increases in the population of uninsured individuals, changes in the states' indigent and Medicaid eligibility requirements, continued efforts by employers to pass more out-of-pocket healthcare costs to employees in the form of increased co-payments and deductibles and the effects of the recent economic environment have resulted in increased levels of uncompensated care.

Medicare

Inpatient Services

Under the Medicare program, hospitals are reimbursed for the operating costs of acute care inpatient stays under an Inpatient Prospective Payment System ("IPPS"), pursuant to which a hospital receives a fixed payment amount per inpatient discharge based on the patient's assigned Medicare severity-adjusted diagnosis-related groups ("MS-DRGs"), a severity-adjusted diagnosis-related group ("DRG") system. Over a two-year transition period that began in October 2007, the Centers for Medicare & Medicaid Services ("CMS") implemented MS-DRGs to replace the previously used Medicare diagnosis related groups in an effort to better recognize severity of illness and cost of providing care in Medicare payment rates. Each MS-DRG is assigned a payment weight that is based on the average amount of hospital resources that are needed to treat Medicare patients in that MS-DRG. MS-DRG payments are adjusted for area wage differentials. In addition, if a hospital treats a patient who is more expensive to treat than the average Medicare patient in the same MS-DRG, the hospital will receive an additional outlier payment if the hospital's cost of treating that patient exceeds a certain threshold amount. MS-DRG classifications and weights are re-calibrated and adjusted on an annual basis to reflect the inflation experienced by hospitals (and entities outside the healthcare industry) in purchasing goods and services (the "market basket index").

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act") were signed into law on March 23, 2010 and March 30, 2010, respectively. The Affordable Care Act contains many Medicare payment initiatives and changes. Some of the changes have not yet gone into effect, but other revisions, such as payments to accountable care organizations ("ACOs"), programs to reduce payments to hospitals for excessive readmissions, and reductions in the hospital market basket update, are effective now.

On August 19, 2013, CMS published its Medicare IPPS final rule for Federal Fiscal Year ("FFY") 2014, which began on October 1, 2013. For FFY2012 (which began on October 1, 2011 and ended on September 30, 2012), FFY2013 (which began on October 1, 2012 and ended on September 30, 2013), and FFY2014, the hospital market basket index increased 3.0%, 2.6% and 2.5%, respectively. For FFY2014, hospitals that do not submit data on quality measures will receive a 0.5% market basket index update. Generally, however, the percentage increase in the DRG payment rate has been lower than the projected increase in the cost of goods and services purchased by hospitals. In addition, as mandated by the Affordable Care Act, the hospital market basket increases for FFY2012, FFY2013 and FFY2014 were reduced by CMS by 0.10%, 0.10%, and 0.30%, respectively. For FFY2012 and each subsequent fiscal year, as also mandated by the Affordable Care Act, the market basket increase is reduced by a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity. For FFY2012, FFY2013 and FFY2014, the productivity adjustment equated to a 1.0%, 0.7% and 0.5% reduction in the market basket increase, respectively. In addition, in FFY2011, FFY2012 and FFY2013, IPPS payment rates to hospitals were increased by 2.9%, decreased by 2.0% and decreased by 1.0%, respectively, for documentation and coding adjustments that were required by the Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007 (the "TMA Act"), and decreased by 0.8% in FFY2014 for additional documentation and coding adjustments required by the American Taxpayer Relief Act of 2012 ("ATRA"). The market basket increase for FFY2014 was also reduced by 0.2% to offset the cost of changes to the Medicare program's admission and medical review criteria for hospital inpatient admissions services. The TMA Act also required CMS to recoup the increase in spending in FFYs

2008 and 2009 by FFY2012. In the IPPS final rule for FFY2011, CMS reduced the standardized amount by (2.9%), which represented half of the required retrospective adjustment. The remaining (2.9%) retrospective reduction was implemented in FFY2012. However, because the (2.9%) retrospective reduction that was made in FFY2011 was restored in FFY2012, the retrospective adjustment that was made in FFY2012 was essentially negated. As noted above, the (2.9%) retrospective reduction that was made in FFY2012 was restored in FFY2013. Lastly, the TMA Act also required CMS to make an additional prospective cumulative adjustment of (3.9%) to eliminate the full effect of the documentation and coding changes on future payments. The TMA Act gave CMS discretion as to the timing of the implementation of the prospective documentation and coding adjustment, and CMS did not implement any portion of the adjustment in FFY2010 and FFY2011. CMS did, however, implement a (2.0%) prospective documentation and coding adjustment in FFY2012 and completed the remaining (1.9%) prospective adjustment in FFY2013.

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With respect to the Medicare program's admission and medical review criteria for inpatient services, in the IPPS final rule for FFY 2014, CMS issued the "two midnight rule", which modified CMS's policy regarding how Medicare contractors will review inpatient hospital services for payment purposes. Under the final rule, in addition to services designated by CMS as inpatient-only services, surgical procedures, diagnostic tests, and other treatments will generally be considered to be appropriate for inpatient admission and inpatient hospital payment under Medicare Part A when the treating physician expects the beneficiary to require a stay that crosses at least two midnights and admits the beneficiary to the hospital based on that expectation. As for medical review, the two midnight rule establishes a presumption that inpatient hospital claims with lengths of stay greater than two midnights will be presumed generally appropriate for reimbursement under Medicare Part A. However, inpatient hospital claims with lengths of stay less than two midnights after the formal admission following the order will not be subject to that presumption and may be reviewed by Medicare contractors and recovery auditors for appropriateness for Medicare Part A payment. When reviewing such claims, the two midnight rule requires Medicare contractors and recovery auditors to evaluate the physician order for admission as well as certain medical documentation. While the two midnight rule became effective on October 1, 2013, CMS originally indicated that, for a period of 90 days after the effective date of the rule, it would not permit recovery auditors to review inpatient admissions of one midnight or less that began on or after October 1, 2013. In guidance regarding the two midnight rule issued by CMS in late 2013, CMS announced that the Medicare Administrative Contractors and recovery auditors would not conduct reviews for compliance for claims with dates of admission between October 1, 2013 and March 31, 2014. On January 31, 2014, CMS announced another delay in enforcement of the two midnight rule, and stated that it is instructing recovery auditors to wait until September 30, 2014, to begin reviewing short inpatient stays.

The IPPS final rule for 2014 also finalized a proposal from a separate proposed rule that provides that if a Medicare Part A claim for inpatient services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines through a specified self-audit process that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may bill Medicare Part B for certain services that were billed under Medicare Part A, provided the beneficiary is enrolled in Medicare Part B.

The IPPS final rule for FFY 2014 also makes changes to the Hospital Inpatient Quality Reporting ("IQR") Program. CMS finalized certain measures for removal in FFY 2016, and suspended additional measures. CMS also made adjustments to some existing measures, and finalized five additional claims based measures for FFY 2016. CMS finalized data submission requirements for voluntary electronic submission of IQR measures in CY 2014 including electronic reporting and chart abstraction requirements. Beginning in FFY 2015, hospitals that do not participate in the IQR program will lose one-quarter of the percentage in their payment updates.

As authorized by the Affordable Care Act, the United States Department of Health and Human Services ("HHS") issued its final rule on April 29, 2011 launching the Hospital Value-Based Purchasing Program (the "VBP Program"). The VBP Program, which began in October 2012, provides that hospitals will be paid for inpatient acute care services based on quality of care measures as specifically set forth by CMS. The quality measures focus on how closely hospitals follow best clinical practices and how well hospitals enhance patients' experiences of care. The higher the quality measures, the higher the reward from CMS. The IPPS final rule for FFY 2014 made some changes to the VBP Program, including finalizing a disaster/extraordinary circumstance exception process under the VBP program for hospitals struck by a natural disaster or experiencing extraordinary circumstances. Under the new policy, CMS allows a hospital to request a Hospital VBP program exception within 90 days of the natural disaster or other extraordinary circumstance. The Company intends for its facilities to achieve high levels of quality under the VBP Program, however, the Company cannot guarantee that its facilities' reimbursement will increase and will not decrease as a result of the implementation of the VBP Program.

The ATRA, which was enacted on January 1, 2013, requires CMS to recoup \$11 billion from IPPS payments in FFYs 2014 through 2017 to offset an additional increase in aggregate payments to hospitals that Congress believes represent overpayments resulting from documentation and coding adjustments from the implementation of the MS-DRG system. In the IPPS final rule for FFY 2014, CMS applied a (0.8%) adjustment as the first step in the recovery process required by ATRA and indicated that it expects to make similar adjustments in FFY 2015, FFY 2016, and FFY 2017 to recover the remaining outstanding amount.

Hospitals that treat a disproportionately large number of low-income patients currently receive additional payments from

Medicare in the form of disproportionate share hospital ("DSH") payments. DSH payments are determined annually based upon certain statistical information defined by CMS and are calculated as a percentage add-on to the MS-DRG payments. This percentage varies, depending on several factors that include the percentage of low-income patients served. However, the Affordable Care Act requires Medicare DSH payments to providers to be reduced by 75% beginning in FFY 2014, subject to adjustment if the Affordable Care Act does not decrease uncompensated care to the extent anticipated. The amount that is withheld will be reduced by the percentage change in uninsured individuals under the age of 65 from 2013 to 2014 (as normalized to reflect the October 1 commencement date for each FFY) minus 0.1% and then paid as additional payments to DSH hospitals based on the amount of uncompensated care provided by each hospital relative to the amount of uncompensated care provided by all hospitals receiving DSH payments during the applicable time period.

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On January 18, 2012, CMS published a proposed rule with a service specific definition of “uncompensated care” for purposes of DSH reductions. Under this definition, uncompensated care would include services provided to insured individuals whose insurance does not cover a particular service or who have exhausted their insurance benefits. Costs associated with bad debt, including unpaid coinsurance and deductibles and payor discounts would not be considered “uncompensated care” under the proposed rule. In the IPPS final rule for FFY 2014, CMS finalized that a hospital’s amount of uncompensated care is defined as a Medicare DSH hospital’s insured low income days, or the sum of a hospital’s Medicare Supplemental Security Income (“SSI”) days and Medicaid days, rather than by actually measuring the amount of uncompensated care that is provided by DSH hospitals. While difficult to predict, the use of Medicaid and Medicare SSI days to approximate levels of uncompensated care could have an adverse effect on DSH hospitals that are located in states that have opted to not expand their Medicaid programs.

Outpatient Payment

Under Medicare’s hospital Outpatient Prospective Payment System (“OPPS”), hospital outpatient services are classified into groups called ambulatory payment classifications (“APCs”). Services in each APC are clinically similar and are similar in terms of the resources they require. CMS establishes a payment rate for each APC, and, depending on the services provided, a hospital may be paid for more than one APC for each patient encounter. APC classifications and payment rates are reviewed and adjusted on an annual basis. Historically, the rate of increase in payments for hospital outpatient services has been higher than the rate of increase in payments for inpatient services.

On November 27, 2013, CMS issued the final OPPS rates for calendar year (“CY”) 2014. Under the final rule, the payment rates under the OPPS were increased by 1.7% for CY 2014. The increase is based on the projected hospital market basket of 2.5% minus 0.8% in statutory reduction, which includes a multifactor productivity adjustment of 0.5%, and a 0.3% percentage point adjustment required by the Affordable Care Act. CMS continues to implement the statutory 2.0% reduction in payments for hospitals failing to meet the hospital outpatient quality reporting requirements. CMS also finalized its proposal to create 29 comprehensive APCs to replace 29 existing device-dependent APCs, but with a modification to apply a complexity adjustment. Implementation of these comprehensive APCs will be delayed until CY 2015. The rule also finalized four new measures for the Hospital Outpatient Quality Reporting (“OQR”) Program, affecting the CY 2016 payment determination and subsequent years, with data collection beginning in CY 2014.

Physician Services

Physician services are reimbursed under the Medicare physician fee schedule (“PFS”) system, under which CMS has assigned a national relative value unit (“RVU”) to most medical procedures and services that reflects the various resources required by a physician to provide the services relative to all other services. Each RVU is calculated based on a combination of work required in terms of time and intensity of effort for the service, practice expense (overhead) attributable to the service and malpractice insurance expense attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs, then aggregated. The aggregated amount is multiplied by a conversion factor that accounts for inflation and targeted growth in Medicare expenditures (as calculated by the sustainable growth rate (“SGR”)) to arrive at the payment amount for each service. While RVUs for various services may change in a given year, any alterations are required by statute to be virtually budget neutral, such that total payments made under the PFS may not differ by more than \$20 million from what payments would have been if adjustments were not made.

The PFS rates are adjusted each year, and reductions in both current and future payments are anticipated. The SGR formula, if implemented, would result in significant reductions to payments under the PFS. Since 2003, Congress has passed fourteen legislative acts delaying application of the SGR formula to the PFS. For CY 2011, CMS issued a final rule that would have applied the SGR formula and resulted in an aggregate reduction of 24.9% to all physician payments under the PFS for FFY 2011. The Medicare and Medicaid Extenders Act of 2010 delayed application of the SGR until January 1, 2012, and the Temporary Payroll Tax Cut Continuation Act of 2011 then delayed application of the SGR for two additional months, through February 29, 2012. On February 22, 2012, the President signed into law a ten-month extension to the SGR cuts, to prevent cuts from taking effect on March 1, 2012. For CY 2014, CMS issued a final rule that would have, in the absence of Congressional action, imposed an overall reduction of 20.1% to all physician payments until the PFS for CY 2014. The Pathway for SGR Reform Act of 2013, which was enacted on December 26, 2013 (the “Pathway Act”), delayed application of the SGR and provided for a

0.5% increase in PFS payment rates through March 31, 2014

On February 2, 2014, the Senate Finance Committee, the House Ways and Means Committee, and the House Energy and Commerce Committee announced that they had agreed upon legislation, the SGR Repeal and Medicare Provider Payment Modernization Act (the "SGR Repeal Act"), that would permanently repeal the SGR and establish a more streamlined and improved incentive payment program that will focus on providing value and quality. Under the SGR Repeal Act, physicians would receive an annual update of 0.5% for CY 2014 through CY 2018, CY 2018 payment rates would be maintained through CY 2023, and, beginning in 2018 through 2023, physicians would be given the opportunity to receive additional payment adjustments through a new Merit-

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Based Incentive Payment System ("MIPS"). MIPS would consolidate three existing incentive programs and improve focus on quality, resource use and meaningful electronic health record ("EHR") use. While the Senate and House Committees have generally agreed on the repeal of the SGR, they have not yet determined how Congress will cover the estimated \$138 billion cost of the legislation. We cannot predict whether the SGR Repeal Act will be adopted by Congress or, if adopted, the impact the SGR Repeal Act would have on our revenues and results of operation.

Budget Control Act

On August 2, 2011, the Budget Control Act of 2011 ("BCA") was enacted. The BCA increased the nation's debt ceiling while taking steps to reduce the federal deficit. The deficit reduction component was implemented in two phases. First, the BCA imposed caps that reduced non-entitlement spending by more than \$900 billion over 10 years, beginning in FFY 2012. Second, a bipartisan Congressional Joint Select Committee on Deficit Reduction (the "Committee") was charged with identifying at least \$1.5 trillion in deficit reduction, which could include entitlement provisions like Medicare reimbursement to providers. On November 21, 2011, the Committee announced that its members were unable to agree on any measures to reduce the deficit, and as a result, \$1.2 trillion in automatic, across-the-board spending reductions required by the BCA are scheduled to be imposed automatically for FFYs 2013 through 2021, split evenly between domestic and defense spending and evenly divided over the nine year period. Certain programs (including the Medicaid program) are protected from these automatic spending reductions, but the Medicare program is subject to reductions capped at 2%. The BCA's automatic spending reductions began March 1, 2013.

On March 1, 2013, President Barack Obama signed an order implementing the automatic spending reductions required by the BCA. Payment reductions to Medicare providers became effective on April 1, 2013. However, among other things, the Pathway Act extends the automatic across-the-board spending reductions required by the BCA through FFY 2023. In addition, it extends the Medicare dependent hospital program, which provides enhanced payment support for rural hospitals that have no more than 100 beds and at least 60% of their inpatient days or discharges covered by Medicare, and the Medicare low volume hospital program, which provides additional Medicare reimbursement for general acute care hospitals that are located a certain distance from another general acute care hospital and have less than a certain number of Medicare discharges each fiscal year, through March 31, 2014.

CMS Disclosure Obligations

In addition to setting payment rates, recent CMS payment rules also imposed disclosure obligations and reporting requirements on physician-owned hospitals. Among other things, the rules require physician-owned hospitals to disclose the names of their physician owners to their patients, require physician-owners who are members of the hospital's medical staff to disclose their ownership interests to the patients they refer to the hospital, and require the hospital to notify all patients in writing at the beginning of their inpatient hospital stay or outpatient visit if a physician is not present in the hospital 24 hours per day, 7 days per week. The notice regarding the presence of a physician must also describe how the hospital will meet the medical needs of patients who develop emergency conditions while no doctor is on the premises. We intend for our facilities to comply with these requirements.

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Medicaid

Medicaid programs are funded jointly by the federal government and the states and are administered by states under approved plans. Most state Medicaid program payments are made under a prospective payment system or are based on negotiated payment levels with individual hospitals. Medicaid reimbursement is less than Medicare reimbursement for the same services and is often less than a hospital's cost of services. The federal government and many states have recently reduced or are currently considering legislation to reduce the level of Medicaid funding (including upper payment limits) or program eligibility that could adversely affect future levels of Medicaid reimbursement received by our hospitals. As permitted by law, certain states in which we operate have adopted broad-based provider taxes to fund their Medicaid programs. Since states must operate with balanced budgets and since the Medicaid program is often the state's largest program, states may consider further reductions in their Medicaid expenditures.

Annual Cost Reports

All hospitals participating in the Medicare and Medicaid programs, whether paid on a reasonable cost basis or under a prospective payment system, must meet specific financial reporting requirements. Federal regulations require submission of annual cost reports identifying medical costs and expenses associated with the services provided by each hospital to Medicare beneficiaries and Medicaid recipients. These annual cost reports are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to us under these reimbursement programs. The audit process may take several years to reach the final determination of allowable amounts under the programs. Providers also have the right of appeal, and it is common to contest issues raised in audits of prior years' reports.

Cost reports filed by our facilities generally remain open for three years after the notice of program reimbursement date. If any of our facilities are found to have been in violation of federal or state laws relating to preparing and filing of Medicare or Medicaid cost reports, whether prior to or after our ownership of these facilities, we and our facilities could be subject to substantial monetary fines, civil and criminal penalties and exclusion from participation in the Medicare and Medicaid programs.

Recovery Audit Contractors

In 2005, CMS began using Recovery Audit Contractors ("RACs") to detect Medicare overpayments not identified through existing claims review mechanisms. The RAC program relies on private auditing firms to examine Medicare claims filed by healthcare providers. The RAC program began as a demonstration project in a few states and was later made permanent by the Tax Relief and Health Care Act of 2006. The permanent RAC program was gradually expanded across the United States in 2008 and 2009 and is currently operating in all 50 states. The Affordable Care Act further expanded the use of RACs and required each state to establish a Medicaid RAC program in 2011.

RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those Medicare claims most likely to contain overpayments, such as incorrectly coded services, incorrect payment amounts, non-covered services and duplicate payments. CMS has given RACs the authority to look back at claims up to three years old, provided that the claim was paid on or after October 1, 2007. Claims identified as overpayments will be subject to the Medicare appeals process.

RACs are paid a contingency fee based on the overpayments they identify and collect. Therefore, we expect that the RACs will look very closely at claims submitted by our facilities in an attempt to identify possible overpayments. Although we believe our claims for reimbursement submitted to the Medicare and Medicaid programs are accurate, many of our hospitals have had claims audited by the RAC program. We cannot predict if this trend will continue or the results of any future audits. These additional post-payment reviews may require us to incur additional costs to respond to requests for records and to pursue the reversal of payment denials and ultimately may require us to refund amounts paid to us that are determined to have been overpaid.

Third-Party Payors

We also are dependent upon private third-party sources of reimbursement for services provided to patients. In addition,

market and cost factors affecting the fee structure, cost containment, and utilization decisions of third-party payors and other payment factors over which we will have no control may adversely affect the amount of payment we will receive for our services. The market share growth of private third-party managed care has resulted in substantial competition among providers of services, including pain management and outpatient and inpatient surgical services, for inclusion in managed care contracting in some markets. In addition, many third-party payor contracts contain termination provisions that allow the payor to terminate the contract without cause after delivering notice of intent to terminate. Termination of a managed care contract can result in material reductions in patient volume and revenue to us. Our financial condition and results of operations may be adversely affected by fixed fee schedules, capitation payment arrangements, exclusion from participation in managed care programs, or other changes in payments for healthcare services.

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Self-Pay and Charity Care

Self-pay revenues are derived primarily from patients who do not have any form of healthcare coverage. We provide care without charge to certain patients that qualify under the Company's charity/indigent care policy. At our hospitals, patients treated for non-elective care, who meet the poverty guideline requirements, are eligible for charity care if they comply with providing supporting documentation. Tennessee, Missouri, Oregon, and Arkansas are based on income at or below 200% of the federal poverty level; Oklahoma and Washington are based on 300% of the federal poverty guideline. The federal poverty level is established by the federal government and is based on income and family size. Our hospitals provide a discount to uninsured patients who do not qualify for Medicaid or charity care. These discounts are similar to those provided to many local managed care plans. In implementing the discount policy, our first attempt is to qualify uninsured patients for Medicaid, other federal or state assistance or charity care. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

Healthcare Reform

The Affordable Care Act dramatically altered the United States healthcare system and is intended to decrease the number of uninsured Americans and reduce overall healthcare costs. The Affordable Care Act attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance, expanding Medicare and Medicaid eligibility, reducing Medicare and Medicaid payments, including DSH payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria and bundling payments to hospitals and other providers. Although some of the measures contained in the Affordable Care Act did not take effect until 2014 and others have been further delayed, certain of the reductions in Medicare spending, such as negative adjustments to the Medicare hospital inpatient and outpatient prospective payment system market basket updates and the incorporation of productivity adjustments to the Medicare program's annual inflation updates, became effective prior to 2013.

The Affordable Care Act also contains several Medicare payment and delivery system innovations, including the establishment of a Medicare Shared Savings Program to promote accountability and coordination of care through the creation of ACOs and the establishment of a pilot program related to bundled payment for post-acute care. Under the bundled post-acute care pilot program, beginning no later than January 1, 2015, Medicare would pay one bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. The Affordable Care Act requires the Secretary of HHS to expand the pilot program if it achieves the stated goals of reducing spending while improving or not reducing quality. The five-year voluntary national bundled payment pilot program for Medicare services would begin no later than January 1, 2013, and expanded, if appropriate, by January 1, 2016. HHS will have the discretion to determine how the program will function. For example, HHS will determine what medical conditions will be included in the program and the amount of the payment for each condition.

CMS finalized the implementation of the Medicare program's Bundled Payments for Care Improvement ("BPCI") initiative in the IPPS final rule for FFY 2013 and announced the healthcare organizations that were selected to participate in BPCI initiative on January 31, 2013. In addition, the Affordable Care Act provides for a five-year bundled payment pilot program for Medicaid services to begin January 1, 2012. HHS selected certain states to participate based on the potential to lower costs under the Medicaid program while improving care. State programs may target particular categories of beneficiaries, selected diagnoses or geographic regions of the state. The selected state programs will provide one payment for both hospital and physician services provided to Medicaid patients for certain episodes of inpatient care.

Under the ACO Medicare Shared Savings Program, ACOs would enter into a contract with the Secretary of the HHS in which the ACO agrees to be accountable for the overall care of its Medicare beneficiaries, to have adequate participation of primary care physicians, to define processes to promote evidence-based medicine, to report on quality and costs, and to coordinate care. ACOs that meet quality and efficiency standards would be allowed to share in the cost savings they achieve for the Medicare program. The final rule outlines certain key characteristics of an ACO, including the scope and length of an ACO's contract with CMS, the required governance of an ACO, the assignment of Medicare beneficiaries to an ACO, the payment models under which an ACO can share in cost savings, and the quality and other reporting requirements expected of an ACO. Under the ACO rule, patient and provider participation in ACOs is voluntary. The ACO program was established January 1, 2012, and providers were able to begin enrolling on a rolling basis, with the first round of applications due in early

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2012. To date, more than 360 ACOs have been established to participate in the Medicare program, and additional ACO programs are being established by private payors.

The Affordable Care Act also contains a number of measures that are intended to reduce fraud and abuse in the Medicare and Medicaid programs, such as requiring the use of RACs in the Medicaid program, expanding the scope of the federal False Claims Act and generally prohibiting physician-owned hospitals from increasing the total percentage of physician ownership or increasing the aggregate number of operating rooms, procedure rooms, and beds for which they are licensed.

As part of the effort to control or reduce healthcare spending, the Affordable Care Act places a number of significant requirements and limitations on the Whole Hospital Exception to the federal physician self-referral prohibition, commonly known as the Stark Law (the "Stark Law"), which allows physicians to have ownership interests in hospitals. Among other things, the Affordable Care Act prohibits hospitals from increasing the percentage of the total value of the ownership interest held in the hospital by physicians after March 23, 2010.

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On June 28, 2012, the United States Supreme Court upheld the “individual mandate” provision of the Affordable Care Act that generally requires all individuals to obtain healthcare insurance or pay a penalty. The Supreme Court also held, however, that the provision of the Act that authorized the Secretary of HHS to penalize states that choose not to participate in the expansion of the Medicaid program by removing all existing Medicaid funding was unconstitutional. As a result, the expansion of the Medicaid program to all individuals all adults under 65 years old with incomes at or under 133% of FPL is now optional. In response to the ruling, a number of states have already indicated that they will not expand their Medicaid programs. Doing so would result in the Affordable Care Act not providing coverage to some low-income persons in those states. Additionally, several bills have been and will likely continue to be introduced in Congress to defund, delay, repeal or amend all or significant provisions of the Affordable Care Act. It is difficult to predict the full impact of the Affordable Care Act because of its complexity, lack of implementing regulations and interpretive guidance, gradual and potentially delayed implementation, potential future legal challenges, and possible defunding, repeal and/or amendment, as well as the inability to foresee how individuals and businesses will respond to the choices afforded them by the Affordable Care Act. Depending on further legislative developments and how the Affordable Care Act is ultimately interpreted and implemented, it could have an adverse effect on the business, financial condition and results of operations of the Company.

Impact of Affordable Care Act on the Company

The expansion of health insurance coverage under the Affordable Care Act may result in a material increase in the number of patients using our facilities who have either private or public program coverage. In addition, a disproportionately large percentage of the new Medicaid coverage is likely to be in states that currently have relatively low income eligibility requirements. Further, the Affordable Care Act provides for a value-based purchasing program, the establishment of ACOs and bundled payment pilot programs, which will create possible sources of additional revenue.

However, it is difficult to predict the size of the potential revenue gains to the Company as a result of these elements of the Affordable Care Act, because of uncertainty surrounding a number of material factors, including the following:

- how many previously uninsured individuals will obtain coverage as a result of the Affordable Care Act (the Congressional Budget Office, or CBO, originally estimated 26 million by 2022, and CMS originally estimated almost 34 million by 2019; both agencies made a number of assumptions to derive those figures, including how many individuals will ignore substantial subsidies and decide to pay the penalty rather than obtain health insurance and what percentage of people in the future will meet the new Medicaid income eligibility requirements. However, in July 2012, the CBO revised its estimate to reflect the impact of the U.S. Supreme Court’s determination that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that choose not to participate in the expansion of the Medicaid program was unconstitutional. The CBO now projects, as a result of the Supreme Court’s decision and other factors, that there will be six million more uninsured individuals in 2014 and four million more uninsured individuals in 2022 than originally projected);
- what percentage of the newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the number of states that elect to expand their Medicaid programs and when that expansion occurs;
- the extent to which states will enroll new Medicaid participants in managed care programs;
- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the rate paid to hospitals by private payers for newly covered individuals, including those covered through the newly created Exchanges and those who might be covered under the Medicaid program under contracts with the state;
- the rate paid by state governments under the Medicaid program for newly covered individuals;
- how the value-based purchasing and other quality programs will be implemented;
- the percentage of individuals in the American Health Benefit Exchanges who select the high deductible plans, since health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals;

- whether the net effect of the Affordable Care Act, including the prohibition on excluding individuals based on pre-existing conditions, the requirement to keep medical costs lower than a specified percentage of premium revenue, other health insurance reforms and the annual fee applied to all health insurers, will be to put pressure on the bottom line of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business; and
- the possibility that implementation of provisions expanding health insurance coverage will be delayed, blocked, revised or eliminated as a result of court challenges and efforts to repeal or amend the new law.

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On the other hand, the Affordable Care Act provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments and the establishment of programs where reimbursement is tied to quality and integration. Since 52.5% of our revenue in 2013 was from Medicare and Medicaid, collectively, reductions to these programs may significantly impact us and could offset any positive effects of the Affordable Care Act. It is difficult to predict the size of the revenue reductions to Medicare and Medicaid spending, because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenue we will generate from Medicare and Medicaid business when the reductions are implemented;
- whether reductions required by the Affordable Care Act will be changed by statute prior to becoming effective;
- the amount of the Medicare DSH reductions that will be made, commencing in FFY 2014;
- the allocation to our hospitals of the Medicaid DSH reductions, commencing in FFY 2016;
- what the losses in revenue will be, if any, from the Affordable Care Act's quality initiatives;
- how successful ACOs, in which we participate, will be at coordinating care and reducing costs;
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs; and
- reductions to Medicare payments CMS may impose for "excessive readmissions."

Because of the many variables involved, we are unable to predict the net effect on the Company of the expected increases in insured individuals using our facilities, the reductions in Medicare spending and reductions in Medicare and Medicaid DSH funding, and numerous other provisions in the Affordable Care Act that may affect us. Additionally, it is unclear how many states will decline to implement the Medicaid expansion in light of the U.S. Supreme Court's ruling. Due to these factors, we are unable to predict with any reasonable certainty or otherwise quantify the likely impact of the Affordable Care Act.

Government Regulation and Other Factors

General

All participants in the healthcare industry are required to comply with extensive government regulation at the federal, state and local levels. In addition, these laws, rules and regulations are extremely complex and the healthcare industry has had the benefit of little or no regulatory or judicial interpretation of many of them. Although we believe we are in compliance in all material respects with such laws, rules and regulations, if a determination is made that we were in material violation of such laws, rules or regulations, our business, financial condition or results of operations could be materially adversely affected. If we fail to comply with applicable laws and regulations, we can be subject to criminal penalties and civil sanctions and our hospitals can lose their licenses and their ability to participate in the Medicare and Medicaid programs.

Licensing, Certification and Accreditation

Healthcare facility construction and operation is subject to complex federal, state and local regulations relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection laws. Our facilities also are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. We believe that all of our operating healthcare facilities are properly licensed under appropriate state healthcare laws.

All of our hospitals are certified under the Medicare program and are accredited by The Joint Commission or the American Osteopathic Association. Some of the Company's facilities have used Joint Commission or American Osteopathic Association accreditation in lieu of Medicare surveys to obtain Medicare certification. For those facilities, the effect of accreditation is to permit the facilities to participate in the Medicare and Medicaid programs. If any facility that obtained Medicare participation based on its accreditation loses that accreditation status, or any of our facilities otherwise lose certification under the Medicare program, then the facility will be unable to receive reimbursement from the Medicare and Medicaid programs. We intend to conduct our operations in compliance with current applicable federal, state, local and independent review body regulations and

standards. The requirements for licensure, certification and accreditation are subject to change and, in order to remain qualified, we may need to make changes in our facilities, equipment, personnel and services.

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Utilization Review

Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients be reviewed by quality improvement organizations that analyze the appropriateness of Medicare and Medicaid patient admissions and discharges, quality of care, validity of diagnosis-related group classifications and appropriateness of cases of extraordinary length of stay or cost. Quality improvement organizations may deny payment for services provided, assess fines and recommend to the Department that a provider not in substantial compliance with the standards of the quality improvement organization be excluded from participation in the Medicare program. Most non-governmental managed care organizations also require utilization review.

Medicare Participation

Our facilities have received certification under the federal Medicare program in order to qualify for reimbursement for services rendered to eligible patients under such program. The Medicare program has conditions of participation that a provider must satisfy to qualify for reimbursement including, but not limited to, compliance with state licensure requirements, governing body and management requirements, medical records requirements, credit balance refund requirements, quality assurance and utilization review requirements, surgical service standards, physical environment standards, nursing services standards, pharmaceutical standards, laboratory and radiological standards, medical staff credentialing standards, and architectural standards. We intend for all of our facilities to comply with all applicable Medicare conditions and requirements. However, the failure to obtain, or any loss or restriction of, Medicare certification may adversely affect our financial viability. In addition, any significant reduction in government payments for services provided at our facilities could have a material adverse effect on our business.

The requirements for certification and enrollment under Medicare and other government reimbursement programs such as Medicaid are subject to change and, in order to remain qualified for such programs, it may be necessary for us to make changes from time to time in its facilities, equipment, personnel or services.

Anti-Kickback Laws

The Social Security Act includes provisions addressing illegal remuneration (the "Anti-Kickback Laws") which prohibit providers and others from, among other things, soliciting, receiving, offering or paying, directly or indirectly, any remuneration in return for either making a referral for a service or item covered by a federal healthcare program or ordering or arranging for or recommending the order of any covered service or item. Violations of the Anti-Kickback Laws are felonies that include criminal penalties or imprisonment or criminal fines up to \$25,000 per violation. In addition, violations of the Anti-Kickback Laws also include civil monetary penalties of up to \$50,000 per violation, damages up to three times the total amount of the improper payment made to the referral source, and exclusion from participation in Medicare, Medicaid, or other tendered healthcare programs.

In *U.S. v. Greber*, 760 F.2d 68 (3d Cir. 1985), the United States Court of Appeals for the Third Circuit held that the Anti-Kickback Laws are violated if one purpose (as opposed to a primary or sole purpose) of a payment to a provider is to induce referrals. Other federal circuit courts have followed the *Greber* case.

Under regulations issued by the Office of the Inspector General ("OIG"), certain categories of activities are deemed not to violate the Anti-Kickback Laws (the "Safe Harbors"). According to the preamble to the Safe Harbors, the failure of a particular business arrangement to comply with the regulations does not determine whether the arrangement violates the Anti-Kickback Laws. The Safe Harbors do not make conduct illegal, but instead delineate standards that, if complied with, protect conduct that might otherwise be deemed in violation of the Anti-Kickback Laws. Currently there are safe harbors for various activities, including the following: investment interests, space rental, equipment rental, practitioner recruitment, personal services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, ambulatory surgery centers and referral agreements for specialty services.

The Affordable Care Act increases funding for fighting fraud and abuse, allows CMS to establish enrollment moratoria in areas identified as being at elevated risk of fraud, creates new penalties for fraud and abuse violations, increases penalties for submitting false claims, and restricts physician ownership of hospitals.

We have a variety of financial relationships with physicians who refer patients to our facilities. As of December 31, 2013, referring physicians owned interests in five of our hospitals, and four outpatient facilities in which we own a minority interest. We may sell ownership interests in certain other of our facilities to physicians and other qualified investors in the future. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases and professional service agreements. We have provided financial incentives to recruit physicians to relocate to communities served by our hospitals, including income and collection guarantees and reimbursement of relocation costs, and will continue to provide recruitment packages in the future. Although we have established policies and procedures to ensure that our arrangements with physicians comply with

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current law and applicable regulations, we cannot assure you that regulatory authorities that enforce these laws will not determine that some of these arrangements violate the Anti-Kickback Statute or other applicable laws. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal healthcare programs, any of which could have a material adverse effect on our business, financial condition or results of operations.

The Stark Law

Physician self-referral laws have been enacted by Congress and many states to prohibit certain self-referrals for healthcare services. The federal prohibition, commonly known as the Stark Law, prohibits physicians from referring patients for certain designated health services provided by an entity with which the physician has a financial relationship if those services are paid for, in whole or in part, by Medicare or Medicaid. The Stark Law also prohibits the entity from seeking payment from Medicare or Medicaid for services rendered pursuant to a prohibited referral. If an entity is paid for services rendered pursuant to a prohibited referral, it may incur civil penalties of up to \$15,000 per prohibited claim and may be excluded from participating in Medicare and Medicaid.

Under the Stark Law, designated health services include inpatient and outpatient hospital services; radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; physical therapy services; occupational therapy services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home healthcare services; and outpatient prescription drugs. Our facilities provide designated health services under the Stark Law.

As discussed below, the Affordable Care Act creates potential False Claims Act liability for failure to timely report and repay known overpayments to the federal government, including payments received for services rendered pursuant to referrals that are not Stark Law compliant. In 2010, CMS published a self-referral disclosure protocol (the "SDP") to encourage providers to disclose and attempt to resolve potential Stark Law violations and related overpayment liabilities at levels below the maximum penalties and amounts set forth by statute. In light of these developments, we may make certain disclosures through the SDP in the future. We cannot predict how CMS will resolve any issues reported through the SDP, including whether CMS will resolve any potential Stark Law violations are related overpayments at levels below the maximum amounts set forth by law.

Laws allowing physicians to refer their patients to facilities in which they have an investment interest are presently, and are expected to continue to be, the focus of federal and state lawmakers. The Stark Law prohibits a physician from having a financial relationship in and making referrals to an entity that provides designated health services, which includes inpatient or outpatient hospital services, unless an exception applies to the financial relationship. The Stark Law provides several exceptions including exceptions for leases and personal services agreements as long as the arrangements comply with the parameters of the exceptions. In addition, there are exceptions for investments in rural areas, and there is a Whole Hospital Exception that, prior to the recent reform legislation, allowed physicians to own interests in hospitals. The Affordable Care Act also prohibits an increase in the aggregate number of beds, operating rooms, and procedure rooms in physician-owned hospitals from March 23, 2010; requires a referring physician owner or investor to disclose his or her ownership interest in a hospital (along with the ownership or investment interest of any treating physician) to patients at a time when the patient may make a meaningful decision regarding the receipt of care; requires physician-owned hospitals to submit an annual report identifying each physician owner and investor, and the nature and extent of all ownership and investment interests; requires physician-owned hospitals to disclose any physician ownership or investment interest on the hospital's website and in any public advertisement; and ensures that ownership in hospitals by physician owners or investors is bona fide and satisfies the Whole Hospital Exception.

In addition to the physician referral requirements, the Stark Law also includes specific reporting requirements that require each entity furnishing covered items or services to provide the Secretary with certain information concerning its ownership, investment, and compensation arrangements with physicians. In a series of notices in 2007, CMS indicated its intent to require a group of 500 hospitals to submit a Disclosure of Financial Relationships Report ("DFRR") to CMS that contains detailed information concerning each hospital's ownership, investment, and compensation arrangements with physicians. CMS has since determined that mandating hospitals to complete the DFRR may duplicate some of the reporting obligations related to physician ownership and investment set forth in the Affordable Care Act. Therefore, CMS has decided to delay implementation

of the DFRR, and instead focus on implementing relevant sections of the Affordable Care Act. CMS has indicated that it remains interested in analyzing physician compensation relationships with DHS entities, and after collecting and examining information related to ownership and investment interests pursuant to the Affordable Care Act, it will determine if it is necessary to capture information related to compensation arrangements. If CMS continues with the DFRR requirement and one of our facilities receives the DFRR request, it will have a limited amount of time to compile a significant amount of information relating to its financial relationships with physicians, including any ownership by physicians. Our facilities may be subject to substantial penalties if it is unable to assemble and report this information within the required timeframe or if CMS or any other government agency determines that its submission is inaccurate or incomplete. In addition, a facility may be the subject of investigations or enforcement actions if a government agency determines that any of the information indicates a potential violation of law. Any such investigation or enforcement action could materially adversely affect the Company's results of operations. These activities reflect the general trend of increasing governmental scrutiny of the financial relationships between hospitals and referring physicians under the Stark Law.

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Corporate Practice of Medicine and Fee Splitting

Some of the states in which we operate have laws that prohibit unlicensed persons or business entities, including corporations, from employing physicians or laws that prohibit certain direct or indirect payments or fee-splitting arrangements between physicians and unlicensed persons or business entities. Possible sanctions for violations of these restrictions include loss of a physician's license, civil and criminal penalties and rescission of business arrangements that may violate these restrictions. These statutes vary from state to state, are often vague and seldom have been interpreted by the courts or regulatory agencies. Although we exercise care to structure our arrangements with healthcare providers to comply with the relevant state law and believe these arrangements comply with applicable laws in all material respects, we cannot assure you that governmental officials responsible for enforcing these laws will not assert that we, or transactions in which we are involved, are in violation of such laws, or that such laws ultimately will be interpreted by the courts in a manner consistent with our interpretations.

HIPAA Privacy, Transaction and Security Standards

HIPAA required HHS to promulgate regulations designed to encourage electronic commerce in the healthcare industry. These regulations apply to healthcare providers that transmit information in an electronic form in connection with standard HIPAA transactions, such as electronic claims.

At this time, HHS has promulgated standards for the HIPAA transactions, standards for unique identifiers for employers and healthcare providers to be used in the HIPAA transactions, standards for the privacy of individually identifiable information, security standards for the protection of electronic health information and general administrative requirements relating to procedures for investigating violations of HIPAA, the imposition of penalties for such violations and procedures for hearings to appeal the imposition of penalties. The Company's facilities are subject to these standards.

HIPAA security standards require our Company's facilities to establish and maintain reasonable and appropriate administrative, technical and physical safeguards to ensure the integrity, confidentiality and the availability of electronic health and related financial information. The security standards were designed to protect electronic information against reasonably anticipated threats or hazards to the security or integrity of the information and to protect the information against unauthorized use or disclosure.

HIPAA privacy standards apply to individually identifiable health information held or disclosed by our facilities in any form, whether communicated electronically, on paper or orally. These standards impose extensive new administrative requirements on our facilities, including appointing a privacy officer, adopting privacy policies and training our facilities' workforce on these policies. They require our facilities' compliance with rules governing the use and disclosure of health information. They create new rights for patients in their health information, such as the right to access and amend their health information and request an accounting for certain disclosure of their health information, and they require our facilities to impose these rules, by contract, on any business associate to whom our facilities disclose such information in order to perform functions on our facilities' behalf. In addition, our facilities will continue to remain subject to any state laws that are more restrictive than the privacy standards issued under HIPAA.

A violation of these regulations could result in civil money penalties of \$100 per incident, up to a maximum of \$25,000 per person per year per standard. HIPAA also provides for criminal penalties of up to \$50,000 and one year in prison for knowingly and improperly obtaining or disclosing protected health information, up to \$100,000 and five years in prison for obtaining protected health information under false pretenses, and up to \$250,000 and ten (10) years in prison for obtaining or disclosing protected health information with the intent to sell, transfer or use such information for commercial advantage, personal gain or malicious harm. Since there is no significant history of enforcement efforts by the federal government at this time, it is not possible to ascertain the likelihood of enforcement efforts in connection with the HIPAA regulations or the potential for fines and penalties which may result from the violation of the regulations.

On February 17, 2009, President Obama signed the ARRA into effect. The ARRA included the HITECH Act, which contains a number of provisions that significantly expand the reach of HIPAA. Among other things, the HITECH Act (i) created new security breach notification requirements for covered entities (ii) extended the HIPAA security provisions to business associates, and (iii) increased a patient's ability to restrict access to his or her protected health information. The

HITECH Act also expanded the number of enforcement mechanisms that are available to prosecute violations of HIPAA by creating a private cause-of-action for non-compliance which may be brought by state attorneys general on behalf of affected patients and increasing the civil monetary penalties that may be imposed for violations of HIPAA by establishing a tiered penalty system.

On August 24, 2009, HHS issued regulations implementing certain of the requirements of the HITECH Act, including the breach notification requirements providing obligations for compiling and reporting of certain information relating to breaches by providers and their business associates (the "Interim Final Breach Rule"), effective September 23, 2009. HHS subsequently

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promulgated and withdrew a final breach notification rule for review, but it intends to publish a final data breach rule in the coming months. Until such time as a new final breach rule is issued, the Interim Final Breach Rule remains in effect. In addition, our facilities remain subject to any state laws that relate to the reporting of data breaches that are more restrictive than the regulations issued under HIPAA and the requirements of the HITECH Act. Additionally, the HITECH Act requires periodic audits of covered entities and business associates conducted by governmental subcontractors to ensure their compliance with the HIPAA privacy and security regulations. In 2011, HHS initiated a pilot audit program that ran until December 2012 in the first phase of HHS implementation of this requirement. We cannot predict whether our facilities will be selected for an audit and the results of such an audit.

On January 17, 2013, HHS issued a final rule (the "Final HIPAA Rule") which, among other things, made final modifications to the HIPAA privacy, security, and enforcement rules mandated by the HITECH Act; adopted changes to the HIPAA enforcement rule to incorporate the increased and tiered civil money penalty structure provided by the HITECH Act; adopted a final rule on Breach Notification for Unsecured Protected Health Information, which replaces the breach notification rule's prior "harm" threshold with a more objective standard; and modified the HIPAA privacy rule as required by the Genetic Information Nondiscrimination Act (GINA). Our facilities were required to comply with applicable requirements of the Final HIPAA Rule beginning on September 23, 2013, except that existing business associate agreements may qualify for an extended compliance date of September 23, 2014. We cannot yet quantify the financial impact of compliance with these new regulations. We could, however, incur expenses associated with such compliance.

Violations of the HIPAA privacy and security regulations may result in civil and criminal penalties. The HITECH Act and Final HIPAA Rule significantly increased the penalties for violations by introducing a tiered penalty system reflecting increasing levels of culpability, with penalties of up to \$50,000 per violation with a maximum civil penalty of \$1.5 million for violations of the same requirement in a calendar year. The HITECH Act and Final HIPAA Rule also extended the application of certain provisions of the security and privacy regulations to business associates and imposes direct civil and criminal liability on business associates for violation of the HIPAA regulations. The HITECH Act also authorizes state attorneys general to bring civil actions seeking either injunction or damages up to \$25,000 for violations of the same requirement in a calendar year in response to violations of HIPAA privacy and security regulations that affect their state residents. The applicable state laws regulating the privacy of patient health information could impose additional penalties. We expect increased enforcement of the requirements of HIPAA, the HITECH Act, and the Final HIPAA Rule by HHS and state attorneys general.

The Company intends to comply fully with HIPAA and the applicable portions of the HITECH Act, when required. However, the Company cannot provide any assurances that the Company's actions will not be reviewed or challenged by the authorities having responsibility for HIPAA enforcement. The Company expects that compliance with these standards will require significant commitment and action by the Company.

In January 2009, CMS published its 10th revision of International Statistical Classification of Diseases ("ICD-10"), which establishes an updated code set to be used for classifying health care diagnoses and procedures. Entities covered under HIPAA will be required to use the ICD-10, which contains significantly more diagnostic and procedural codes than the existing ICD-9 coding system. Because of the greater number of codes, the coding for the services provided in our facilities will require much greater specificity. Implementation of ICD-10 will require a significant investment in technology and training. We may experience delays in reimbursement while our facilities and the payors from which we seek reimbursement make the transition to ICD-10. While HIPAA originally required implementation of ICD-10 to be achieved by October 1, 2013, HHS issued a final rule on September 5, 2012, extending the deadline to October 1, 2014. If any of our facilities fail to implement the new coding system by the deadline, the affected facility will not be paid for services. We are not able to predict the timeframe or the overall financial impact of the transition to ICD-10.

Federal Trade Commission "Red Flags Rule"

On November 9, 2007, the Federal Trade Commission ("FTC") issued a final rule, known as the Red Flags Rule, that requires financial institutions and other businesses which maintain accounts that are used for primarily individual purposes and that permit multiple payments, to implement written identity theft prevention programs. The FTC may seek penalties of up to \$3,500 per violation for certain violations of the Red Flags Rule. In addition, states may enforce the Red Flags Rule on behalf of their citizens by either (i) seeking direct damages or (ii) penalties of up to \$1,000 per independent violation, plus attorney's

fees. Finally, affected individuals may also file civil suits in which they may recover actual damages, plus attorney's fees, for negligent violations, or actual damages of up to \$1,000, plus attorney's fees and punitive damages, for willful noncompliance.

The Red Flag Program Clarification Act of 2010, signed on December 18, 2010, appears to exclude certain healthcare providers from the Red Flags Rule, but permits the FTC or relevant agencies to designate additional creditors subject to the Red Flags Rule through future rulemaking if the agencies determine that the person in question maintains accounts subject to foreseeable risk of identity theft. The Company intends to comply with the Red Flags Rule if required. However, the Company cannot provide any assurances that its operations and identity theft prevention programs will not be reviewed or challenged by the FTC or other governmental authorities with responsibility for enforcing the Red Flags Rule, or if challenged, that its operations and programs would be found to be compliant.

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False and Other Improper Claims

The U.S. government is authorized to impose criminal, civil and administrative penalties on any person or entity that files a false claim for payment from the Medicare or Medicaid programs. Claims filed with private insurers can also lead to criminal and civil penalties, including, but not limited to, penalties relating to violations of federal mail and wire fraud statutes. While the criminal statutes are generally reserved for instances of fraudulent intent, the U.S. government is applying its criminal, civil and administrative penalty statutes in an ever expanding range of circumstances. For example, the government has taken the position that a pattern of claiming reimbursement for unnecessary services violates these statutes if the claimant merely should have known the services were unnecessary, even if the government cannot demonstrate actual knowledge. The government has also taken the position that claiming payment for low quality services is a violation of these statutes if the claimant should have known that the care was substandard. In addition, some courts have held that a violation of the Stark law can result in liability under the federal False Claims Act. Additionally, under the Affordable Care Act, the False Claims Act is implicated by the knowing failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later, and the Affordable Care Act also specifically provides that submission of claims for services or items generated in violation of the Anti-Kickback Laws constitutes a false or fraudulent claim under the False Claims Act.

Over the past several years, the U.S. government has accused an increasing number of healthcare providers of violating the federal False Claims Act. The False Claims Act prohibits a person from knowingly presenting, or causing to be presented, a false or fraudulent claim to the U.S. government. The statute defines “knowingly” to include not only actual knowledge of a claim’s falsity, but also reckless disregard for or intentional ignorance of the truth or falsity of a claim. Because our facilities perform hundreds of similar procedures a year for which they are paid by Medicare, and there is a relatively long statute of limitations, a billing error or cost reporting error could result in significant civil or criminal penalties. Under the “qui tam,” or whistleblower, provisions of the False Claims Act, private parties may bring actions on behalf of the U.S. government. These private parties, often referred to as relators, are entitled to share in any amounts recovered by the government through trial or settlement.

Both direct enforcement activity by the government and whistleblower lawsuits have increased significantly in recent years and have increased the risk that a healthcare provider, such as one of our facilities, will have to defend a false claims action, pay fines or be excluded from the Medicare and Medicaid programs as a result of an investigation resulting from a whistleblower case. Risk to our facilities is further increased by the Affordable Care Act’s elimination of the requirement that a whistleblower be an original source of information, thereby easing barriers to filing of whistleblower suits. Although it is believed that our facilities’ operations materially comply with both federal and state laws, one of our facilities or the Company itself may nevertheless be the subject of a whistleblower lawsuit, or may otherwise be challenged or scrutinized by governmental authorities. A determination that the Company or one of our facilities violated these laws could have a material adverse effect on the Company.

The Emergency Medical Treatment and Active Labor Act

The Federal Emergency Medical Treatment and Active Labor Act (“EMTALA”) was adopted by the U.S. Congress in response to reports of a widespread hospital emergency room practice of “patient dumping.” At the time of the enactment, patient dumping was considered to have occurred when a hospital capable of providing the needed care sent a patient to another facility or simply turned the patient away based on such patient’s inability to pay for his or her care. The law imposes requirements upon physicians, hospitals and other facilities that provide emergency medical services. Such requirements pertain to what care must be provided to anyone who comes to such facilities seeking care before they may be transferred to another facility or otherwise denied care. The government broadly interprets the law to cover situations in which patients do not actually present to a hospital’s emergency department, but present to a hospital-based clinic that treats emergency medical conditions on an urgent basis or are transported in a hospital-owned ambulance, subject to certain exceptions. EMTALA does not generally apply to patients admitted for inpatient services. Sanctions for violations of this statute include termination of a hospital’s Medicare provider agreement, exclusion of a physician from participation in Medicare and Medicaid programs and civil monetary penalties. In addition, the law creates private civil remedies that enable an individual who suffers personal harm as a direct result of a violation of the law, and a medical facility that suffers a financial loss as a direct result of another participating hospital’s violation of the law, to sue the offending hospital for damages and equitable relief. Although we believe

that our practices are in substantial compliance with the law, we cannot assure you that governmental officials responsible for enforcing the law will not assert from time to time that our facilities are in violation of this statute.

Certificates of Need

In some states, the construction of new facilities, acquisition of existing facilities or addition of new beds or services may be subject to review by state regulatory agencies under a certificate of need program. Oklahoma, Tennessee and Washington are the only states in which we currently operate that require approval of acute care hospitals under a certificate of need program. These laws generally require appropriate state agency determination of public need and approval prior to the addition of beds or services or other capital expenditures. Failure to obtain necessary state approval can result in the inability to expand facilities, add services and complete an acquisition or change ownership. Further, violation may result in the imposition of civil sanctions or the revocation of a facility's license.

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Environmental Matters

We are subject to various federal, state and local laws and regulations relating to environmental protection. The principal environmental requirements and concerns applicable to our operations relate to:

- the proper handling and disposal of hazardous and low level medical radioactive waste;
- ownership or historical use of underground and above-ground storage tanks;
- management of impacts from leaks of hydraulic fluid or oil associated with elevators, chiller units or incinerators;
- appropriate management of asbestos-containing materials present or likely to be present at some locations; and
- the potential acquisition of, or maintenance of air emission permits for, boilers or other equipment.

We do not expect our compliance with environmental laws and regulations to have a material effect on us. We may also be subject to requirements related to the remediation of substances that have been released into the environment at properties owned or operated by us or at properties where substances were sent for off-site treatment or disposal. These remediation requirements may be imposed without regard to fault and whether or not we owned or operated the property at the time that the relevant releases or discharges occurred. Liability for environmental remediation can be substantial.

Competition

The hospital industry is highly competitive. We currently face competition from established not-for-profit healthcare systems, investor-owned hospital companies, large tertiary care hospitals, specialty hospitals and outpatient service providers. In the future, we expect to encounter increased competition from companies, like ours, that consolidate hospitals and healthcare companies in specific geographic markets. Continued consolidation in the healthcare industry will be a leading factor contributing to increased competition in our current markets and markets we may enter in the future. Because of the shift to outpatient care and more stringent payor-imposed pre-authorization requirements during the past few years, most hospitals have significant unused capacity resulting in increased competition for patients. Many of our competitors are larger than us and have more financial resources available than we do. Other not-for-profit competitors have endowment and charitable contribution resources available to them and can purchase equipment and other assets on a tax-free basis.

Employees and Medical Staff

As of December 31, 2013, we had approximately 5,560 employees, including approximately 1,340 part-time employees. Approximately 249 of our full-time employees at our Olympia, Washington hospital are unionized. While some of our non-unionized hospitals experience union organizing activity from time to time, currently we do not expect these efforts to affect our future operations materially. Our hospitals, like most hospitals, have experienced labor costs rising faster than the general inflation rate.

While the national nursing shortage has abated somewhat as a result of the weakened U.S. economy, certain pockets of the markets we serve continue to have limited available nursing resources. Nursing shortages often result in our using more contract labor resources to meet increased demand, especially during the peak winter months. We expect our nurse leadership and recruiting initiatives to mitigate the impact of the nursing shortage. These initiatives include more involvement with nursing schools, participation in more job fairs, recruiting nurses from abroad, implementing preceptor programs, providing flexible work hours, improving performance leadership training, creating awareness of our quality of care and patient safety initiatives and providing competitive pay and benefits. We anticipate that demand for nurses will continue to exceed supply especially as the baby boomer population reaches the ages where inpatient stays become more frequent. We continue to implement best practices to reduce turnover and to stabilize our nursing workforce over time.

Annually we develop a strategic physician recruitment and retention plan for each of our hospitals. Executing these plans, we have recruited 31 physicians, 37 physicians and 41 physicians for the years ended December 31, 2011, 2012 and 2013, respectively. We have recruited specialists in areas such as general surgery, cardiology, women's services and orthopedics, as well as primary care physicians, including hospitalists and physicians practicing in areas such as family medicine, internal medicine and pediatrics. Recruitment of family practice and internal medicine physicians as well as mid-levels is critical to building a solid foundation of referring physicians in our markets.

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Our hospitals grant staff privileges to licensed physicians who may serve on the medical staffs of multiple hospitals, including hospitals not owned by us. A physician who is not an employee can terminate his or her affiliation with our hospital at any time. Although we employ a growing number of physicians, a physician does not have to be our employee to be a member of the medical staff of one of our hospitals. Any licensed physician may apply to be admitted to the medical staff of any of our hospitals, but admission to the staff must be approved by each hospital's medical staff and Board of Trustees in accordance with established credentialing criteria. Under state laws and other licensing standards, hospital medical staffs are generally self-governing

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organizations subject to ultimate oversight by the hospital's local governing board. In an effort to meet community needs in certain markets in which we operate, we have implemented a strategy of employing physicians, with an emphasis on those practicing within primary care and other certain specialties. While we believe this strategy is consistent with industry trends, we cannot be assured of the long-term success of such a strategy.

Compliance Program

We maintain a company-wide Ethics & Compliance program designed to ensure that we maintain high standards of ethical conduct in the operation of our business. We continually implement policies and procedures for all of our employees, so they can act in compliance with all applicable laws, regulations and Company policies. The organizational structure of our Ethics & Compliance program includes oversight by Capella's Board of Directors and a high-level Corporate Ethics & Compliance Committee ("CECC"). The Board of Directors and the CECC are responsible for ensuring that the compliance program meets its stated goals and remains up-to-date to address the current regulatory environment and other issues affecting the healthcare industry. Our Chief Compliance Officer, or CCO, who is also our Executive Vice President, Chief Legal and Administrative Officer, is charged with direct responsibility for the day-to-day oversight of our compliance program. Other features of our compliance program include initial and periodic ethics and compliance training and effectiveness reviews, a toll-free hotline for employees to report, without fear of retaliation, any suspected legal or ethical violations, and annual "coding audits" to make sure our hospitals bill the proper service codes for reimbursement from the Medicare program.

Our compliance program also oversees the implementation and monitoring of the standards set forth by HIPAA for privacy and security. Ongoing HIPAA compliance also includes self-monitoring of HIPAA policy and procedure implementation by each of our healthcare facilities and oversight by the CECC and the CCO.

Our Information Systems

We believe that our information systems must cost-effectively meet the needs of our hospital management, medical staff and nurses in a variety of areas of our business operations, such as:

- patient accounting, including billing and collection of revenue;
- accounting, financial reporting and payroll;
- coding and compliance;
- laboratory, radiology and pharmacy systems;
- medical records and document storage;
- physician access to patient data;
- quality indicators;
- materials and asset management; and
- negotiating, pricing and administering our managed care contracts.

We believe that the importance of and reliance upon information technology ("IT") will continue to increase in the future. Accordingly, we expect to make additional significant investments in information technology during the next several years as part of our business strategy to increase the efficiency and quality of patient care.

Although we map the financial information systems from each of our hospitals to one centralized database, we do not automatically standardize our financial information systems among all of our hospitals. We carefully review the existing systems at the hospitals we acquire. If a particular information system is unable to cost-effectively meet the operational needs of the hospital, we will convert or upgrade the information system at that hospital to a standardized information system that can cost-effectively meet these needs.

The ARRA included approximately \$26.0 billion in funding for various healthcare IT initiatives, including incentives for hospitals and physicians to implement EHR-compatible systems. Implementation of these IT initiatives has been divided into three stages, with stage 1 requiring satisfaction in 2012. Stage 1 requires providers and physicians to meet "meaningful use"

standards, which include electronically capturing health information in structured format, tracking key clinical conditions for coordination of care purposes, implementing clinical decision support tools to facilitate disease and medication management, using EHRs to engage patients and families, and reporting clinical quality measures and public health information. We are currently on track to meet the meaningful use standards. Though additional investments in hardware and software will be required, we believe our historical capital investments in information systems, as well as quality of care programs, provide a solid platform to build upon for timely compliance with the healthcare IT requirements of the ARRA.

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Professional and General Liability Insurance

As is typical in the healthcare industry, we are subject to claims and legal actions by patients and others in the ordinary course of business. For professional and general liability claims, we self-insure the first portion of each claim, and Auriga Insurance Group ("Auriga"), a wholly-owned subsidiary of Capella Holdings, Inc. ("Holdings"), insures the next portion of each claim. We maintain excess coverage from independent third-party carriers for claims exceeding the coverage provided by Auriga from Lloyds of London for the first portion of the excess policy and the Bermuda market for the remaining portion. Auriga funds its portion of claims costs from proceeds of premium payments received from us.

We believe that our current insurance program provides sufficient coverage for our facilities. We cannot, however, ensure that potential claims will not exceed those amounts. Consistent with the policy limits and indemnification agreements, our insurance coverage will cover insured professional/general liability claims made against us, during the time such insurance is in force, consistent with the policy terms and conditions; however, our insurance policy covers the members of our Board of Directors and the boards of our subsidiaries only with respect to acts performed in their capacity as board members.

Emerging Growth Company

Capella believes that it qualifies as an "emerging growth company" under the Jumpstart Our Business Startups Act, or the JOBS Act. Capella should maintain this status until the earliest of the last day of the fiscal year during which it has total annual gross revenues of more than \$1 billion, the last day of the fiscal year following the fifth anniversary of the date of the first sale of common equity securities pursuant to an effective registration statement, the date on which it has issued more than \$1 billion in non-convertible debt during the previous three years, or the date on which it is deemed to be a "large accelerated filer." For as long as Capella remains an "emerging growth company" as defined in the JOBS Act, it may take advantage of certain exemptions from various reporting requirements that are applicable to "emerging growth companies" including, but not limited to, reduced disclosure obligations regarding executive compensation in our periodic reports.

Item 1A. Risk Factors.

There are several factors, some beyond our control, that could cause results to differ significantly from our expectations. Some of these factors are described below. Other factors, such as market, operational, liquidity, interest rate and other risks, are described elsewhere in this report (see, for example, Part II, Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*). Any factor described in this report could by itself, or together with one or more factors, adversely affect our business, results of operations and/or financial condition. There may be factors not described in this report that could also cause results to differ from our expectations.

We cannot predict the effect that healthcare reform and other changes in government programs may have on our financial condition or results of operations.

The Affordable Care Act dramatically altered the United States healthcare system and is intended to decrease the number of uninsured Americans and reduce overall healthcare costs. The Affordable Care Act attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance, expanding Medicare and Medicaid eligibility, reducing Medicare and Medicaid payments, including DSH payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, and bundling payments to hospitals and other providers. The Affordable Care Act also contains a number of measures that are intended to reduce fraud and abuse in the Medicare and Medicaid programs, such as requiring the use of RACs in the Medicaid program, expanding the scope of the federal False Claims Act and generally prohibiting physician-owned hospitals from increasing the total percentage of physician ownership or increasing the aggregate number of operating rooms, procedure rooms, and beds for which they are licensed. Because some of the measures contained in the Affordable Care Act did not take effect until 2014, it is difficult to predict the impact the Affordable Care Act will have on our facilities. In addition, a number of the provisions of the Affordable Care Act that were scheduled to become effective in 2014, such as the employer mandate, the Small Business Health Option Program, and the state run exchange verification of income and Medicaid agency electronic notification of eligibility for tax credit and subsidy requirements, have been delayed until 2015, and additional delays in the implementation of these or other provisions of the Affordable Care Act could be imposed in the future. Several bills have been and will likely continue to be introduced in Congress to defund, delay, repeal or amend all or significant provisions of the Affordable Care

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Act. It is difficult to predict the full impact of the Affordable Care Act because of its complexity, lack of implementing regulations and interpretive guidance, state decisions to decline Medicaid expansion, gradual and potentially delayed implementation, potential future legal challenges, and possible repeal and/or amendment, as well as our inability to foresee how individuals and businesses will respond to the choices afforded them by the Affordable Care Act.

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Spending cuts resulting from the Budget Control Act of 2011 may have a material adverse effect on our financial position, results of operation or cash flow.

On August 2, 2011, the Budget Control Act of 2011, or BCA, was enacted. The BCA increased the nation's debt ceiling while taking steps to reduce the federal deficit. First, the BCA imposed caps that reduced non-entitlement spending by more than \$900 billion over 10 years, beginning in FFY 2012. Second, a bipartisan Committee was charged with identifying at least \$1.5 trillion in deficit reduction, which could include entitlement provisions like Medicare reimbursement to providers. On November 21, 2011, the Committee announced that its members were unable to agree on any measures to reduce the deficit, and as a result, \$1.2 trillion in automatic, across-the-board spending reductions required by the BCA are scheduled to be imposed automatically for FFYs 2013 through 2021, split evenly between domestic and defense spending. The Pathway Act extended those reductions through FFY 2023. Certain programs (including the Medicaid program) are protected from these automatic spending reductions, but the Medicare program is subject to reductions capped at 2%. On January 1, 2013, the ATRA delayed the imposition of the BCA's automatic spending reductions from January 2, 2013 to March 1, 2013, with CMS implementing the 2% reduction in Medicare spending on April 1, 2013. The BCA's automatic spending reductions began March 1, 2013, and are scheduled to reduce Medicare spending by \$9.9 billion. The automatic spending cuts or other Congressional action on other spending reductions proposed by the Committee may reduce the revenue we receive from governmental payment programs or impose additional restrictions on those programs intended to decrease the long-term cost of such programs. Any such reductions may have a material adverse effect on our financial position, results of operation or cash flow.

Our overall business results may suffer from the lingering effects of the economic downturn.

The United States economy continues to experience the negative effects from an economic downturn and unemployment levels remain high. During economic downturns, governmental entities often experience budgetary constraints as a result of increased costs and lower than expected tax collections. These budgetary constraints may result in decreased spending for health and human service programs, including Medicare, Medicaid and similar programs, which represent significant payor sources for our hospitals. Additionally, when patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for hospitals. Moreover, we could experience increases in the uninsured and underinsured populations and difficulties in collecting patient co-payment and deductible receivables. Although the recent passage of the Affordable Care Act is intended to decrease the number of uninsured legal U.S. residents, many of the reform measures do not become effective until 2014 and will not have an immediate impact.

The growth of uninsured and "patient due" accounts and a deterioration in the collectability of these accounts could affect our results of operations adversely.

The primary collection risks of our accounts receivable relate to the uninsured patient accounts and patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and co-payments) remain outstanding. The provision for bad debts relates primarily to amounts due directly from patients. This risk has increased, and will likely continue to increase, as more individuals enroll in insurance plans with high deductibles or with high co-payments. These trends will likely be exacerbated if general economic conditions remain challenging or if unemployment levels in the communities in which we operate rise.

The amount of our provision for bad debts is based on our assessments of historical collection trends, business and economic conditions, trends in federal and state governmental and private employer health coverage and other collection indicators. A continuation in trends that results in increasing the proportion of accounts receivable being composed of uninsured accounts and deterioration in the collectability of these accounts could adversely affect our collections of accounts receivable, results of operations and cash flows. As enacted, the Affordable Care Act seeks to decrease, over time, the number of uninsured individuals. However, it is difficult to predict the full impact of the Affordable Care Act because of its complexity, lack of implementing regulations and interpretive guidance, state decisions to decline Medicaid expansion, gradual and potentially delayed implementation, potential future legal challenges, and possible repeal and/or amendment, as well as our inability to foresee how individuals and businesses will respond to the choices afforded them by the Affordable Care Act. In addition, even after implementation of the Affordable Care Act, we may continue to experience bad debts and be required to provide uninsured discounts and charity care for undocumented aliens who are not permitted to enroll in a health insurance

exchange or government healthcare programs.

Our revenue may decline if federal or state programs reduce our Medicare or Medicaid payments.

Approximately 52.0%, 54.5% and 52.5% of our revenue before the provision for bad debts for the years ended December 31, 2011, 2012, and 2013, respectively, came from the Medicare and Medicaid programs, respectively, including Medicare and Medicaid managed plans. In recent years, federal and state governments have made significant changes in the Medicare and Medicaid programs. Some of those changes adversely affect the reimbursement we receive for certain services. For example, CMS has transitioned to full implementation of the MS-DRG system, which represents a refinement to the existing diagnosis-related group system. Future alignments in the MS-DRG system could impact the margins we receive for certain services. Furthermore, the Affordable Care Act provides for material reductions in the growth of Medicare program spending, including reductions in Medicare market basket updates, and Medicare DSH funding.

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Medicaid programs are funded jointly by the federal government and the states and are administered by states under approved plans. Most state Medicaid program payments are made under a prospective payment system or are based on negotiated payment levels with individual hospitals. Since most states must operate with balanced budgets and since the Medicaid program is often the state's largest program, many states in which we operate have adopted, or are considering adopting, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems. The current economic downturn has increased the budgetary pressures on most states, and these budgetary pressures have resulted and likely will continue to result in decreased spending, or decreased spending growth, for Medicaid programs in many states. Future legislation or other changes in the administration or interpretation of government health programs could have a material adverse effect on our business, financial condition and results of operations.

We are subject to regular post-payment inquiries, investigations and audits of the claims we submit to Medicare and Medicaid for payment for our services. These post-payment reviews have increased in recent years as a result of new government cost-containment initiatives, including audits of Medicare and Medicaid claims under the RAC program. RACs were first introduced only in the Medicare program; however, the Affordable Care Act expanded the RAC program's scope to include Medicaid claims by requiring all states to establish programs to contract with RACs in 2011. In addition, CMS employs Medicaid Integrity Contractors ("MICs") to perform post-payment audits of Medicaid claims and identify overpayments. The Affordable Care Act increased federal funding for the MIC program for FFY 2011 and beyond. In addition to RACs and MICs, state Medicaid agencies and other contractors have also increased their review activities. These additional post-payment reviews may require us to incur additional costs to respond to requests for records and to pursue the reversal of payment denials and ultimately may require us to refund amounts paid to us that are determined to have been overpaid.

Our revenue may decline if payments from our third-party payors are reduced or eliminated, or if we are unable to negotiate contracts or maintain satisfactory relationships with third-party payors.

In addition to governmental programs, we are dependent upon private third-party sources of payment for the services provided to patients at our hospitals. If these payments are reduced, our revenue will decrease. The amount of payment we receive for services provided at our hospitals may be adversely affected by market and cost factors as well as other factors over which we have no control.

Controls designed to reduce inpatient services may reduce our revenue.

Controls imposed by Medicare and commercial third-party payors designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by managed care plans. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payor-required preadmission authorization and utilization review and by payor pressures to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. Fixed fee schedules, capitation payment arrangements, exclusion from participation in managed care programs or other factors affecting payments for healthcare services over which we will have no control could cause a reduction in our revenue.

There has been recent increased scrutiny of a hospital's "Medicare Observation Rate" from outside auditors, government enforcement agencies and industry observers. The term "Medicare Observation Rate" is defined as total unique observation claims divided by the sum of total unique observation claims and total inpatient short-stay acute care hospital claims. A low rate may raise suspicions that a hospital is inappropriately admitting patients that could be cared for in an observation setting. In our hospitals, we use the independent, evidence-based clinical criteria developed by McKesson Corporation, commonly known as InterQual Criteria, to determine whether a patient qualifies for inpatient admission. The industry may anticipate increased regulatory scrutiny of inpatient admission decisions and the Medicare Observation Rate in the future.

We may experience a shortage of qualified professional and staff personnel.

Consistent with a nationwide trend in the healthcare industry, our hospitals have experienced a shortage of nurses and other qualified professional and staff personnel. The shortage of qualified professional and staff personnel may be exacerbated by the development of other healthcare facilities in the market areas of our hospitals.

As a result, our hospitals may utilize contract nurses to ensure adequate patient care, which typically are more expensive than full-time employees. In addition, our hospitals may be forced to implement more costly coverage and retention programs. There can be no assurance that our hospitals will be able to recruit or retain a sufficient number of qualified professional and staff personnel to deliver healthcare services efficiently. Accordingly, our financial condition and results of operations may be affected adversely.

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Our performance depends on our ability to recruit and retain quality physicians.

Physicians generally direct the majority of hospital admissions. Thus, the success of our hospitals depends in part on the following factors:

- the number and quality of the physicians on the medical staffs of our hospitals;
- the admitting practices of those physicians; and
- the development and maintenance of constructive relationships with those physicians.

Most physicians at our hospitals also have admitting privileges at other hospitals. Our efforts to attract and retain physicians are affected by our efforts to promote quality, leadership, satisfaction and intellectual development, our managed care contracting relationships, national shortages in some specialties, the adequacy of our support personnel, the condition of our facilities and medical equipment, the availability of suitable medical office space, and federal and state laws and regulations prohibiting financial relationships that may have the effect of inducing patient referrals. There can be no assurance that our physician recruitment measures, including multi-year employment and/or income guarantee arrangements and other collaborative arrangements will be successful. Also, as we recruit more physicians, the costs associated with integrating and managing these new physicians could have a negative impact on our operating results and liquidity in the short term.

If facilities are not staffed with adequate support personnel or technologically advanced equipment that meets the needs of patients, physicians may be discouraged from referring patients to our facilities, which could affect our profitability adversely. Furthermore, physicians we recruit or employ may fail to maintain successful medical practices, one or more key members of a particular physician group may cease practicing with that group, or other surgeons in the community may refuse to use our hospitals. Although we have been generally successful in our physician recruiting efforts, we cannot assure you of the long-term success of this strategy. We also face continued challenges in some of our markets to recruit certain types of physician specialists who are in high demand.

We are dependent on our executive management team and the loss of the services of one or more of our executive management team could have a material adverse effect on our business.

The success of our business is largely dependent upon the services and management experience of our executive management team. In addition, we depend on the ability of our executive officers and key employees to manage growth successfully and on our ability to attract and retain skilled employees. We do not maintain key man life insurance policies on any of our officers. If we were to lose any of our executive management team or members of our local management teams, or if we are unable to attract other necessary personnel in the future, it could have a material adverse effect on our business, financial condition and results of operations. If we were to lose the services of one or more members of our executive management team, we could experience a significant disruption in our operations and failure of the affected hospitals to adhere to their respective business plans.

If we fail to comply with extensive laws and government regulations, including fraud and abuse laws, we could suffer penalties or be required to make significant changes to our operations.

The healthcare industry is required to comply with many laws and regulations at the federal, state, and local government levels. These laws and regulations require that hospitals meet various requirements, including those relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, compliance with building codes, environmental protection and privacy. These laws include the HIPAA, a section of the Social Security Act, known as the "anti-kickback" statute, and the Stark Law.

There are heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment. The ongoing investigations of certain healthcare providers relate to various referral, inpatient status cost reporting and billing practices, laboratory and home care services, privacy and physician ownership and joint ventures involving hospitals. Moreover, the health reform laws increase funding for fraud and abuse enforcement and increase penalties under the False Claims Act. Federal regulations issued under HIPAA contain provisions that required us to implement and, in the future, may require us to implement additional costly electronic media security systems and to adopt new business procedures designed to protect the privacy and security of each of our patient's

health and related financial information. Such privacy and security regulations impose extensive administrative, physical and technical requirements on us, restrict our use and disclosure of certain patient health and financial information, provide patients with rights with respect to their health information and require us to enter into contracts extending many of the privacy and security regulation requirements to third parties that perform duties on our behalf. Additionally, on January 13, 2013, HHS issued a final rule which, among other things, made final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the HITECH Act; adopted changes to the HIPAA Enforcement Rule to incorporate the increased and tiered civil money penalty structure provided by the HITECH Act; adopted a final rule on Breach Notification for Unsecured Protected Health Information which replaces the breach notification rule's prior "harm" threshold with a more objective standard; and modified the HIPAA Privacy Rule as required by GINA. We are also required to make certain expenditures to help ensure our continued compliance with such laws and regulations and, in the future, such expenses could negatively impact our results of operations. The ARRA included provisions for heightened enforcement of HIPAA and stiffer penalties for HIPAA violations.

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If we fail to comply with applicable laws and regulations, including fraud and abuse laws, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in the Medicare, Medicaid, and other federal and state healthcare programs. Our facilities also are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. If any facility loses its accreditation, it may be in default under its third party payor agreements, make difficult the attraction, negotiation and retention of those agreements on satisfactory terms or at all and could put its Medicare certification at risk if the facility's Medicare certification was obtained through deemed status as a result of the facility's accreditation. If a facility loses its certification under the Medicare program, then the facility will be unable to receive reimbursement from the Medicare and Medicaid programs. The requirements for licensure, certification and accreditation are subject to change and, in order to remain qualified, we may need to make changes in our facilities, equipment, personnel and services.

In the future, changes, different interpretations or enforcement of these laws and regulations, including any changes pursuant to the Affordable Care Act, could subject our current practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs, and operating expenses. For a more detailed discussion of these laws, rules and regulations, see "Item 1. Business — Government Regulation and Other Factors."

CMS may impose substantial fines or other penalties as a result of the matters disclosed in certain self-disclosure letters, which could have a material adverse impact on the results of operations and financial condition Cannon County Hospital, LLC, or CCH, which is a joint venture in which we own a 58.01% interest.

Laws and regulations governing the Medicare, Medicaid and other federal healthcare programs are complex and subject to interpretation. CMS and the OIG allow providers to disclose prior conduct that may have violated those laws and regulations and resolve those issues below the maximum penalties authorized by law. CMS established a Voluntary Self-Referral Disclosure Protocol under the authority provided in the Affordable Care Act, which allows providers to disclose to CMS actual or potential violations of the Stark Law and allows CMS to compromise the total amount of overpayments owed as a result of inadvertent Stark Law violations. Additionally, the OIG is responsible for imposing penalties for Stark Law violations and violations of the anti-kickback statute, which may include civil monetary penalties, imposition of a Corporate Integrity Agreement or exclusion from federal health care programs such as Medicare and Medicaid. CMS does not have the authority to compromise any of the potential penalties that may be imposed by the OIG. Based on the findings from CCH's internal investigation, management of CCH submitted voluntary self-disclosure letters to CMS for each of DeKalb Community Hospital and Stones River Hospital on June 22, 2011 (collectively, the "Self-Disclosure Letters"). The Self-Disclosure Letters disclose certain potentially non-compliant arrangements with physicians under the Stark Law, including lack of certain written agreements with physicians and, solely with respect to Stones River Hospital, administrative failures to ensure that physicians who leased space from CCH executed compliant leases and regularly paid the rental amounts that were due. CCH's current management is unable to predict CMS's response to the Self-Disclosure Letters, the potential liability that may result from the Self-Disclosure Letters or whether CMS may widen the scope of its investigation beyond the matters covered in the Self-Disclosure Letters or refer the matters to any other governmental agencies. If CMS imposes substantial fines as a result of the conduct described in the Self-Disclosure Letters to CMS, it would have a material adverse impact on the results of operations and financial condition of CCH, in which we own a 58.01% interest.

We are subject to competition from other hospitals or healthcare providers, including physicians, which could affect our results of operations adversely.

Our success depends on the effective and efficient operation of our hospitals, which will be affected by competition from other acute care hospitals, free-standing outpatient diagnostic and surgery centers, labs and alternative delivery systems, some of which have substantially greater resources than we do. The healthcare industry is highly competitive. Alternative forms of healthcare delivery systems, such as health maintenance organizations and preferred provider organizations, are significant factors in the delivery of healthcare services and the rates chargeable by physicians and hospitals. Typically, our hospitals' primary competitor is a not-for-profit hospital. Further, our hospitals face competition from hospitals outside of their primary service area, including hospitals in urban areas that provide more complex services. Patients in our primary service areas may travel to these other hospitals for a variety of reasons. These reasons include physician referrals or the need for services we do not offer. Patients who seek services from these other hospitals subsequently may shift their preferences to those hospitals for

the services we provide.

We also face very significant and increasing competition not only from services offered by physicians (including physicians on our medical staffs) in their offices and from other specialized care providers, including outpatient surgery, oncology, physical therapy and diagnostic centers (including many in which physicians may have an ownership interest), but also from physicians owning and operating competing hospitals. Some of our hospitals have and will seek to develop outpatient facilities where necessary to compete effectively. However, to the extent that other providers are successful in developing outpatient facilities or physicians are able to offer additional, advanced services in their offices, our market share for these services likely will decrease in the future.

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Our revenue is especially concentrated in a small number of states which makes us particularly sensitive to regulatory and economic changes in those states.

Our revenue is particularly sensitive to regulatory and economic changes in states in which we generate the majority of our revenue, including Oklahoma and Arkansas. For the years ended December 31, 2011, 2012, and 2013, we generated approximately 48.2%, 55.3%, and 55.5% of our revenue before the provision for bad debts, respectively, in Oklahoma and Arkansas. This concentration makes us particularly sensitive to regulatory, economic, environmental and competitive conditions and changes in those states. Any material change in the current payment programs or regulatory, economic, environmental or competitive conditions in those states could have a disproportionate effect on our overall business results. The economies of the non-urban communities in which our hospitals operate are often dependent on a small number of large employers, especially manufacturing or other facilities. These employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our hospitals for care. The failure of one or more large employers, or the closure or substantial reduction in the number of individuals employed at manufacturing or other facilities located in or near many of the non-urban communities in which our hospitals operate, could cause affected employees to move elsewhere for employment or lose insurance coverage that was otherwise available to them. The occurrence of these events may cause a material reduction in our revenue or impede our business strategies intended to generate organic growth and improve operating results at our hospitals. Any material change in the current demographic, economic, competitive or regulatory conditions in any of our markets could affect our overall business results adversely because of the significance of our operations in each of these markets to our overall operating performance. Moreover, because of the concentration of our revenue in a limited number of markets, our business is less diversified and, accordingly, is subject to greater regional risk than that of some of our larger competitors.

If our access to licensed information systems is interrupted or restricted, or if we are not able to integrate changes to our existing information systems or information systems of acquired hospitals, our operations could suffer.

Our business depends significantly on effective information systems to process clinical and financial information. Information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and develop new systems in order to keep pace with continuing changes in information processing technology. We rely heavily on an affiliate of HCA Holdings, Inc. and another third-party vendor for information systems. These two parties provide us with our primary financial, clinical, revenue cycle management, patient accounting and network information services. HCA's primary business is to own and operate hospitals, not to provide information systems. We do not control these systems, and if these systems fail or are interrupted, if our access to these systems is limited in the future or if these parties develop systems more appropriate for the urban healthcare market and not suited for our hospitals, our operations could suffer.

System conversions are costly, time consuming and disruptive for physicians and employees. Should we decide or be required to convert away from systems provided by third parties, such implementation would be very costly and could have a material adverse effect on our business, financial condition and results of operations.

In addition, as new information systems are developed in the future, we will need to integrate them into our existing systems. Evolving industry and regulatory standards, such as HIPAA and EHR regulations, may require changes to our information systems in the future. For example, the HITECH Act, contains a number of provisions that significantly expand the reach of HIPAA. Among other things, the HITECH Act (i) created new security breach notification requirements for covered entities (ii) extended the HIPAA security provisions to business associates, and (iii) increased a patient's ability to restrict access to his or her protected health information. We may not be able to integrate new systems or changes required to our existing systems or systems of acquired hospitals in the future effectively or on a cost-efficient basis.

Additionally, as required by the ARRA, HHS is in the process of developing and implementing an incentive payment program for eligible hospitals and healthcare professionals that adopt and meaningfully use certified EHR technology. If our hospitals and employed professionals are unable to meet the requirements for participation in the incentive payment program, we will not be eligible to receive incentive payments that could offset some of the costs of implementing EHR systems. Further, beginning in 2015, eligible hospitals and professionals that fail to demonstrate meaningful use of certified EHR technology will be subject to reduced payments from Medicare. Failure to implement EHR systems effectively and in a timely manner could have a material adverse effect on our financial position and results of operations.

We may be subject to liabilities for professional liability and other claims brought against our facilities.

We may be liable for damages to persons or property arising from occurrences at our hospitals. We maintain casualty, professional and general liability insurance through Auriga, in amounts and with deductibles that we believe to be appropriate for our operations. Our reserves for professional and general liability claims and workers compensation claims are based upon independent third-party actuarial calculations, which consider historical claims data, demographic considerations, severity factors and other actuarial assumptions in determining reserve estimates. If the assumptions underlying the third-party actuarial calculations prove to be materially different from actual claims brought against us, our reserves may be insufficient. We also carry excess layers should a claim

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exceed Auriga's aggregate cap. If we become subject to claims, however, our insurance coverage (i) may not cover all successful professional and general liability claims brought against us or (ii) continue to be available at a cost allowing us to maintain adequate levels of insurance. If one or more successful claims against us were not covered by or exceeded the coverage of our insurance, we could be affected adversely.

We are subject to potential legal and reputational risk as a result of our access to personal information of our patients.

There are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access to or theft of personal information. As a provider of health care services, we process, transmit and store sensitive or confidential data, including electronic health records and other personally identifiable information of our patients. The secure processing, maintenance and transmission of this information is critical to our operations and business strategy. We have developed a comprehensive set of policies and procedures in our efforts to comply with HIPAA and other privacy and information security laws. In 2011, the HHS Office for Civil Rights imposed, for the first time, civil monetary penalties and imposed a corrective action plan on a covered entity for violating HIPAA's privacy and information security rules. In addition, state attorneys general have brought civil actions seeking injunctions and damages in response to violations of HIPAA's privacy and security rules. The breach, loss or other compromise of such personal health information could disrupt the operations of one or more facilities, damage our reputation, result in regulatory penalties, legal claims and liability under HIPAA and other state and federal laws, which could have a material adverse effect on our business, financial condition and results of operations.

Future capital commitments, acquisitions or joint ventures may require significant resources, may be unsuccessful or could expose us to unforeseen liabilities.

As part of our growth strategy, we may pursue acquisitions or joint ventures of hospitals or other related healthcare facilities and services. These acquisitions or joint ventures may involve significant cash expenditures, debt incurrence, additional operating losses and expenses that could have a material adverse effect on our business, financial condition and results of operations. Acquisitions or joint ventures involve numerous risks, including:

- difficulty and expense of integrating acquired operations into our business;
- diversion of management's time from existing operations;
- potential loss of key employees or physicians of acquired facilities; and
- assumption of the liabilities and exposure to unforeseen liabilities of acquired companies, including liabilities for failure to comply with healthcare regulations.

We cannot assure you that we will succeed in obtaining financing for acquisitions or joint ventures at a reasonable cost, or that such financing will not contain restrictive covenants that limit our operating flexibility. Further, volatility and disruption of the capital and credit markets and adverse changes in the United States and global economies may further impact our ability to access both available and affordable financing. We also may be unable to operate acquired hospitals profitably or succeed in achieving improvements in their financial performance.

Additionally, many states, including some where we have hospitals and others where we may in the future attempt to acquire hospitals, have adopted legislation regarding the sale or other disposition of hospitals operated by not-for-profit entities. In other states that do not have specific legislation, the attorneys general have demonstrated an interest in these transactions under their general obligations to protect charitable assets from waste. These legislative and administrative efforts focus primarily on the appropriate valuation of the assets divested and the use of the sale proceeds by the not-for-profit seller. These review and approval processes can add time to the consummation of an acquisition of a not-for-profit hospital, and future actions on the state level seriously could delay or even prevent future acquisitions of not-for-profit hospitals. Furthermore, as a condition to approving an acquisition, the attorney general of the state in which the hospital is located may require us to maintain specific services, such as emergency departments, or to continue to provide specific levels of charity care, which may affect our decision to acquire or the terms upon which we acquire one of these hospitals.

If we fail to enhance our hospitals with the most recent technological advances in diagnostic and surgical equipment, our ability to maintain and expand our markets may be affected adversely.

Technological advances with respect to computed axial tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) equipment, as well as other equipment used in our facilities, are continually evolving. In an effort to provide high quality patient care and to compete with other healthcare providers, we must constantly evaluate our equipment needs and upgrade equipment as a result of technological improvements. Such equipment costs typically range from \$1.0 million to \$3.0 million, exclusive of construction or build-out costs. If we fail to remain current with the technological advancements of the medical community, our volumes and revenue may be impacted negatively.

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Difficulties with major expansion projects may involve significant capital expenditures that could have an adverse impact on our liquidity.

We may decide to construct major expansion projects to existing hospitals in order to achieve our growth objectives. Our ability to complete new expansion projects on budget and on schedule would depend on a number of factors, including, but not limited to:

- our ability to control construction costs;
- adverse weather conditions;
- shortages of labor or materials;
- our ability to obtain necessary licensing and other required governmental authorizations; and
- other unforeseen problems and delays.

As a result of these and other factors, we cannot assure you that if we decide to pursue major expansion projects we will not experience greater construction or other expansion costs than originally planned in connection with expansion projects.

State efforts to regulate the construction or expansion of healthcare facilities could impair our ability to operate and expand our operations.

Some states, including the ones in which we operate, require healthcare providers to obtain prior approval, known as a certificate of need ("CON"), for the purchase, construction or expansion of healthcare facilities, to make certain capital expenditures or to make changes in services or bed capacity. In giving approval, these states consider the need for additional or expanded healthcare facilities or services. The failure to obtain any requested CON could impair our ability to operate or expand operations. Any such failure could, in turn, adversely affect our ability to attract patients to our facilities and grow our revenue, which would have an adverse effect on our results of operations.

The industry trend toward value-based purchasing may negatively impact our revenue.

There is a trend in the healthcare industry toward value-based purchasing of healthcare services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care provided by facilities. Governmental programs, including Medicare and Medicaid, require hospitals to report certain quality data to receive full reimbursement updates. In addition Medicare does not reimburse for care related to certain preventable adverse events (also called "never events"). Many large commercial payors currently require hospitals to report quality data, and several commercial payors do not reimburse hospitals for certain preventable adverse events. Furthermore, we implemented a policy pursuant to which we do not bill patients or third-party payors for fees or expenses incurred as a result of certain preventable adverse events. We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could impact our revenue negatively.

A majority of the employees of Capital Medical Center and its related clinics are union members and subject to the terms of collective bargaining agreements.

Capital Medical Center is currently a party to collective bargaining agreements with two local unions that represent all of the employees of that hospital with the exception of professional employees, managerial employees, confidential employees, guards and supervisors (as those terms are defined in the National Labor Relations Act). The terms of the collective bargaining agreements set forth certain criteria related to the hospital's employment practices, seniority, hours of work and overtime, holidays, use and redemption of paid time off, extended illness bank, vacation scheduling, compensation, pay practice, health and non-health benefits, leaves of absence, grievance procedures, disability accommodations and the hospital's drug and alcohol policies. If Capital Medical Center is unable to meet any such criteria, it could result in discussions with union representatives that could be costly and time-consuming for that facility. Furthermore, the terms of the collective bargaining agreements constrain our flexibility as general partner of Capital Medical Center with respect to certain employee issues. Other facilities could experience unionizing activity, which could increase our labor costs materially.

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Our interest in EASTAR Health System will expire at the end of the lease term.

We currently lease or sublease EASTAR Health System and related properties pursuant to a forty-year lease with Muskogee Medical Center Authority, which expires in 2047 (the "Muskogee Lease"). Under the terms of the Muskogee Lease, EASTAR and related properties will revert automatically to the Muskogee Medical Center Authority or the City of Muskogee, as applicable, upon the expiration or termination of the Muskogee Lease. The Muskogee Lease also grants the Muskogee Medical Center Authority the option to purchase some or all of the assets owned by us and used in connection with the operation of EASTAR and related properties in the event the Lease expires or is terminated. Upon the expiration or termination of the Muskogee Lease, our interest in EASTAR and related properties will cease.

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Table of Contents***GTCR indirectly controls us and may have conflicts of interest with us or you in the future.***

Capella was formed in April 2005 by four former executives of Province Healthcare with the support of a significant equity commitment by certain investment funds affiliated with GTCR Golder Rauner II L.L.C. (collectively, with GTCR Golder Rauner, LLC and certain affiliated entities, referred to as "GTCR"). GTCR owns 79.1% of Holdings common stock, which in turn owns 100% of the outstanding shares of Capella's common stock. GTCR elects a majority of the board of directors of Holdings and Capella and controls all matters affecting us, including any determination with respect to:

- our direction and policies;
- the acquisition and disposition of assets;
- future issuances of common stock, preferred stock or other securities;
- our future incurrence of debt; and
- any dividends on our common stock or preferred stock.

The interests of GTCR could conflict with our interests. If we encounter financial difficulties or are unable to pay our debts as they mature, the interests of our equity holders might conflict with those of our company. In addition, GTCR may have an interest in pursuing acquisitions, divestitures, financings or other transactions, that, in its judgment, could enhance its equity investment even though such transactions might involve risks to our company. In addition, GTCR is in the business of making investments in companies and may from time to time acquire interests in businesses that directly or indirectly compete with our business.

Our hospitals are subject to potential responsibilities and costs under environmental laws that could lead to material expenditures or liability.

We are subject to various federal, state and local environmental laws and regulations, including those relating to the protection of human health and the environment. We could incur substantial costs to maintain compliance with these laws and regulations. To our knowledge, we have not been and are not currently the subject of any investigations relating to noncompliance with environmental laws and regulations. We could become the subject of future investigations, which could lead to fines or criminal penalties if we are found to be in violation of these laws and regulations. The principal environmental requirements and concerns applicable to our operations relate to proper management of hazardous materials, hazardous waste and medical waste, above-ground and underground storage tanks, operation of boilers, chillers and other equipment, and management of building conditions, such as the presence of mold, lead-based paint or asbestos. Our hospitals engage independent contractors for the transportation and disposal of hazardous waste, and we require that our hospitals be named as additional insureds on the liability insurance policies maintained by these contractors.

We also may be subject to requirements related to the remediation of substances that have been released into the environment at properties owned or operated by us or our predecessors or at properties where substances were sent for off-site treatment or disposal. These remediation requirements may be imposed without regard to fault, and liability for environmental remediation can be substantial.

Our substantial indebtedness could affect our financial condition adversely.

As of December 31, 2013, our total consolidated indebtedness was approximately \$557.4 million. We also have the ability to incur substantial additional indebtedness in the future. The terms of our indenture and our senior secured asset based loan (the "ABL") do not fully prohibit us or our subsidiaries from doing so. The ABL provides commitments of up to \$100.0 million (not giving effect to any outstanding letters of credit, which would reduce the amount available under our ABL), of which approximately \$73.9 million would have been available for future borrowings as of December 31, 2013. In addition, we may seek to increase the borrowing availability under the ABL. All of those borrowings would be senior and secured. As of December 31, 2013, we had no outstanding borrowings under the ABL.

Our business and financial results depend on our ability to generate sufficient cash flow to service our debt or refinance our indebtedness on commercially reasonable terms.

Our ability to make payments on and to refinance our debt and fund planned expenditures depends on our ability to generate cash flow in the future. Our cash flow, to some extent, is subject to general economic, financial, competitive, legislative and regulatory factors and other factors that are beyond our control. We cannot guarantee that our business will generate cash flow from operations or that future borrowings will be available to us under the ABL in an amount sufficient to enable us to pay our debt or to fund our other liquidity needs. We cannot guarantee that we will be able to refinance our borrowing arrangements or any other outstanding debt on commercially reasonable terms or at all. Refinancing our borrowing arrangements could cause us to:

- pay interest at a higher rate;
- be subject to additional or more restrictive covenants than currently provided in our debt agreements; and
- grant additional security interests in our assets.

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Our inability to generate sufficient cash flow to service our debt or refinance our indebtedness on commercially reasonable terms would have a material adverse effect on our business, financial condition and results of operations.

Operating and financial restrictions in our debt agreements limit our operational and financial flexibility.

The ABL and our indenture contain a number of significant covenants that, among other things, restrict our ability to:

- incur additional indebtedness or issue preferred stock;
- pay dividends on or make other distributions or repurchase our capital stock or make other restricted payments;
- make investments;
- enter into certain transactions with affiliates;
- issue dividends or other payments from restricted subsidiaries to Holdings or other restricted subsidiaries;
- create liens;
- designate our subsidiaries as unrestricted subsidiaries; and
- sell certain assets or merge with or into other companies or otherwise dispose of all or substantially all of our assets.

In addition, under the ABL, we are required to satisfy and maintain specified financial ratios and tests. Events beyond our control may affect our ability to comply with those provisions, and we may not be able to meet those ratios and tests. The breach of any of these covenants would result in a default under the ABL and the lenders could elect to declare all amounts borrowed under the ABL, together with accrued interest, to be due and payable and could proceed against the collateral securing that indebtedness. Because borrowings under the ABL are secured by certain of our assets and certain assets of our subsidiaries, borrowings under the ABL are superior in right of payment to the notes to the extent of the assets securing the ABL. If any of our indebtedness were to be accelerated, our assets may not be sufficient to repay in full our outstanding indebtedness.

Under the ABL, when (and for as long as) the availability under the ABL is less than a specified amount for a certain period of time, or if an event of default has occurred and is continuing, funds deposited into any of our depository accounts will be transferred on a daily basis into a blocked account with the administrative agent and applied to prepay loans under the asset-based revolving credit facility and, if an event of default has occurred and is continuing, to cash collateralize letters of credit and swingline loans issued thereunder and certain other contingent obligations arising in connection with the ABL.

Our capital expenditure and acquisition strategy requires substantial capital resources. The building of new hospitals and the operations of our existing hospitals and newly acquired hospitals require ongoing capital expenditures for construction, renovation, expansion and the addition of medical equipment and technology. More specifically, we are currently, and may in the future be, contractually obligated to make significant capital expenditures relating to the facilities we acquire. Also, construction costs to build new hospitals are substantial. Our debt agreements may restrict our ability to incur additional indebtedness to fund these expenditures.

A breach of any of the restrictions or covenants in our debt agreements could cause a cross-default under other debt agreements. A significant portion of our indebtedness then may become immediately due and payable. We are not certain whether we would have, or be able to obtain, sufficient funds to make these accelerated payments. If any senior debt is accelerated, our assets may not be sufficient to repay in full such indebtedness and our other indebtedness.

As a holding company, we rely on payments from our subsidiaries in order for us to satisfy our financial obligations.

We are a holding company with no significant operations of our own. Because our operations are conducted through our subsidiaries, we depend on dividends, loans, advances and other payments from our subsidiaries in order to allow us to satisfy our financial obligations. Our subsidiaries are separate and distinct legal entities and have no obligation to pay any amounts to us, whether by dividends, loans, advances or other payments. The ability of our subsidiaries to pay dividends and make other payments to us depends on their earnings, capital requirements and general financial conditions and is restricted by, among other things, applicable corporate and other laws and regulations as well as, in the future, agreements to which our subsidiaries may be a party.

Item 1B. Unresolved Staff Comments.

None.

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Item 2. Properties.

The table below presents certain information with respect to our hospitals as of December 31, 2013. For information about our discontinued operations and recent sales of assets, please refer to Note 3 to the consolidated financial statements included elsewhere in this report.

<u>Hospital</u>	<u>Location</u>	<u>Acquisition/Opening/ Lease Date</u>	<u>Licensed Beds</u>	<u>Real Property Status</u>
Capital Medical Center	Olympia, WA	December 1, 2005	110	Own(1)
DeKalb Community Hospital	Smithville, TN	July 1, 2011	71	Own(2)
Grandview Medical Center(6)	Jasper, TN	December 1, 2005	70	Own
Mineral Area Regional Medical Center	Farmington, MO	March 1, 2008	135	Own
EASTAR Health System (formerly Muskogee Regional Medical Center)	Muskogee, OK	April 3, 2007	320	Lease
National Park Medical Center	Hot Springs, AR	March 1, 2008	166	Own(3)
River Park Hospital	McMinnville, TN	December 1, 2005	125	Own(4)
Southwestern Medical Center	Lawton, OK	December 1, 2005	199	Own
St. Mary's Regional Medical Center	Russellville, AR	March 1, 2008	170	Own
Stones River Hospital	Woodbury, TN	July 1, 2011	60	Own(2)
Highlands Medical Center (formerly White County Community Hospital)	Sparta, TN	March 1, 2008	60	Own(5)
Willamette Valley Medical Center	McMinnville, OR	March 1, 2008	88	Own
Total Licensed Beds			1,574	

- (1) This hospital is owned and operated by us in a joint venture with physicians in which we own 90.25% and physicians or physician entities own the remaining 9.75%.
- (2) These two hospitals are owned and operated by us through CCH, which is a joint venture with physicians in which we own 58.01% and physicians or physician entities own 35.50%. Through a joint venture agreement, St. Thomas Health owns 6.49% of the hospitals.
- (3) This hospital is owned and operated by us in a joint venture with physicians in which we own 95.29% and physicians or physician entities own the remaining 4.71%.
- (4) This hospital is owned and operated by us in a joint venture with St. Thomas Health in which we own 93.51% and St. Thomas Health owns the remaining 6.49%.
- (5) This hospital is owned and operated by us in a joint venture with physicians in which we own 81.23% and physicians or physician entities own 12.28%. Through a joint venture agreement, St. Thomas Health owns 6.49% of the hospital.
- (6) The Company sold this hospital effective March 1, 2014.

In each of the joint ventures listed above, the managing members or general partners, as applicable, are one or more of our wholly-owned subsidiaries (each a "Capella Owner"). Each Capella Owner manages the day-to-day operation of the hospital in exchange for a management fee and reimbursement of its out-of-pocket expenses. In addition, our Capital Medical Center, Highlands Medical Center and CCH joint ventures participate in our cash management system pursuant to a Cash Management Agreement and Revolving Credit Loan (the "Cash Management Agreement"). Under the Cash Management Agreement, we may but are not obligated to, provide the applicable joint venture with working capital revolving credit loans as we deem necessary or appropriate for the conduct of the joint venture's business.

In addition to the hospitals listed above we own, either directly or through an interest in a joint venture, certain outpatient service locations complementary to our hospitals. We also own, operate and/or lease medical office buildings in conjunction with certain of our hospitals, which are primarily occupied by physicians practicing at our hospitals.

As of December 31, 2013, we leased approximately 17,000 square feet of office space at 501 Corporate Centre Drive, Suite 200, Franklin, Tennessee, for our corporate headquarters. Our headquarters, hospitals and other facilities are suitable for their respective uses and are, in general, adequate for our present needs.

Item 3. Legal Proceedings.

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Hospitals are subject to the regulation and oversight of various state and federal governmental agencies. Further, under the federal False Claims Act, private parties have the right to bring qui tam, or "whistleblower," suits against hospitals that submit false claims for payments to, or improperly retain overpayments from, governmental payors. Some states have adopted similar state whistleblower and false claims provisions. The healthcare industry has seen a number of ongoing investigations related to patient referrals, physician recruiting practices, cost reporting and billing practices, laboratory and home healthcare services, physician ownership of hospitals and other healthcare providers, and joint ventures involving hospitals and physicians. Hospitals continue to be one of the primary focal areas of the OIG and other governmental fraud and abuse programs. Certain of our individual facilities have received, and from time to time, other facilities may receive, government inquiries from federal and state agencies. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on our financial position, results of operations and liquidity.

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In addition, hospitals are, from time to time, subject to claims and suits arising in the ordinary course of business, including claims for damages for personal injuries, medical malpractice, breach of contracts, wrongful restriction of or interference with physicians' staff privileges and employment related claims. In certain of these actions, plaintiffs request payment for damages, including punitive damages that may not be covered by insurance.

We are currently not a party to any pending or threatened proceeding, which, in management's opinion, would have a material adverse effect on our business, financial condition or results of operations.

Item 4. Mine Safety Disclosures.

Not applicable.

Table of Contents**PART II****Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.**

We are wholly owned by Capella Holdings, Inc., or Holdings, of which GTCR owns 79.1%. There is no public trading market for our equity securities or those of Holdings. As of January 31, 2014, there were 122 holders of Holdings common stock.

Item 6. Selected Financial Data.

The following table contains our selected financial data for, or as of the end of, the last five years ended December 31, 2013. The selected financial data has been derived from our audited consolidated financial statements. The timing of acquisitions and divestitures completed during the years presented below affects the comparability of the selected financial data. The selected financial data excludes the operations, as well as assets and liabilities, of our discontinued operations in our consolidated financial statements. We have also recognized certain transaction and debt costs during certain of the periods presented that affected the comparability of the selected financial data. You should read this table in conjunction with the consolidated financial statements and related notes included elsewhere in this report and in Part II, Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*.

	Year Ended December 31,				
	2009	2010	2011	2012	2013
	(Dollars in millions)				
Statement of Operations Data:					
Revenue before provisions for bad debts	\$686.6	\$ 732.9	\$723.7	\$802.3	\$ 828.5
Less: Provision for bad debts	(86.1)	(107.8)	(72.3)	(84.1)	(106.2)
Revenue	600.5	625.1	651.4	718.2	722.3
Costs and expenses:					
Salaries and benefits (includes stock compensation of \$0.3, \$0.3, \$0.8, \$1.0, and \$0.8, respectively)	290.6	301.6	313.9	333.2	342.8
Supplies	96.6	105.4	108.3	114.8	123.1
Other operating expenses	123.1	124.5	144.7	177.7	185.5
Other income	—	—	(7.2)	(6.4)	(12.6)
Depreciation and amortization	31.6	30.7	31.8	37.8	44.2
Interest, net	48.5	48.4	51.1	53.1	55.0
Management fee to related party	0.2	0.2	0.2	0.2	0.2
Loss on refinancing	—	20.8	—	—	—
Total costs and expenses	590.6	631.6	642.8	710.4	738.2
Income (loss) from continuing operations before income taxes	9.9	(6.5)	8.6	7.8	(15.9)
Income taxes	2.2	3.2	1.4	3.0	4.0
Income (loss) from continuing operations	7.7	(9.7)	7.2	4.8	(19.9)
Loss from discontinued operations, net of tax	(5.2)	(4.5)	(20.5)	(17.6)	(11.4)
Net income (loss)	\$ 2.5	\$ (14.2)	\$ (13.3)	\$ (12.8)	\$ (31.3)
Less: Net income attributable to non-controlling interests	0.9	1.5	1.2	1.3	0.5
Net income (loss) attributable to Capella Healthcare, Inc.	\$ 1.6	\$ (15.7)	\$ (14.5)	\$ (14.1)	\$ (31.8)
Other Financial Data:					
Adjusted EBITDA(1)	\$ 90.5	\$ 93.9	\$ 94.6	\$105.4	\$ 87.6

	As of December 31,				
	2009	2010	2011	2012	2013
	(Dollars in millions)				
Balance Sheet Data:					
Cash and cash equivalents	\$ 19.6	\$ 48.3	\$ 42.4	\$ 33.3	\$ 26.4

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Property and equipment	461.7	450.7	426.5	473.6	456.1
Total assets	756.3	767.8	787.8	844.4	830.8
Long-term debt, including current portion	484.5	494.1	495.1	551.8	557.4
Working capital(2)	97.3	119.2	109.9	88.0	82.8

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- (1) "EBITDA," a measure used by management to evaluate operating performance, is defined as net income plus (i) provision for income taxes, (ii) interest expense and (iii) depreciation and amortization. EBITDA is not a recognized term under GAAP and does not purport to be an alternative to net income as a measure of operating performance or to cash flows from operating activities as a measure of liquidity. Additionally, EBITDA is not intended to be a measure of free cash flow available for management's discretionary use, as it does not consider certain cash requirements such as interest payments, tax payments and other debt service requirements. Management believes EBITDA is helpful in highlighting trends because EBITDA excludes the results of decisions that are outside the control of operating management and that can differ significantly from company to company depending on long-term strategic decisions regarding capital structure, the tax jurisdictions in which companies operate and capital investments. Management compensates for the limitations of using non-GAAP financial measures by using them to supplement GAAP results to provide a more complete understanding of the factors and trends affecting the business than GAAP results alone. Because not all companies use identical calculations, our presentation of EBITDA may not be comparable to similarly titled measures of other companies.

"Adjusted EBITDA" is defined as EBITDA plus (i) net income attributable to non-controlling interests, (ii) loss on refinancing, (iii) loss from discontinued operations, (iv) acquisition-related expenses, (v) stock compensation expense and (vi) management fee to related party, if any, for the applicable period. We believe that the inclusion of supplementary adjustments to EBITDA applied in presenting adjusted EBITDA are appropriate to provide additional information to investors about the impact of certain noncash items, unusual items that we do not expect to continue at the same level in the future and other items.

The following table presents a reconciliation to provide a more detailed analysis of these non-GAAP performance measures:

	Year Ended December 31,				
	2009	2010	2011	2012	2013
	(Dollars in millions)				
Net income (loss) attributable to Capella Healthcare, Inc.	\$ 1.6	\$(15.7)	\$(14.5)	\$(14.1)	\$(31.8)
Plus taxes	2.2	3.2	1.4	3.0	4.0
Plus net interest expense and deferred financing cost amortization	48.5	48.4	51.1	53.1	55.0
Plus depreciation and amortization	31.6	30.7	31.8	37.8	44.2
EBITDA	<u>\$83.9</u>	<u>\$ 66.6</u>	<u>\$ 69.8</u>	<u>\$ 79.8</u>	<u>\$ 71.4</u>
Plus net income attributable to non-controlling interests	\$ 0.9	\$ 1.5	\$ 1.2	\$ 1.3	\$ 0.5
Plus loss on refinancing	—	20.8	—	—	—
Plus loss from discontinued operations	5.2	4.5	20.5	17.6	11.4
Acquisition-related expenses	—	—	2.1	5.5	3.3
Stock compensation	0.3	0.3	0.8	1.0	0.8
Plus management fee to related party	0.2	0.2	0.2	0.2	0.2
Adjusted EBITDA	<u>\$90.5</u>	<u>\$ 93.9</u>	<u>\$ 94.6</u>	<u>\$105.4</u>	<u>\$ 87.6</u>

- (2) We define working capital as current assets minus current liabilities. For 2011 and 2013, working capital excludes the impact of assets and liabilities held for sale, which is shown as a current asset and current liability on the consolidated balance sheet for those years. For 2013, working capital also excludes the current portion of debt.

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The following table sets forth certain unaudited operating data for each of the periods presented.

	Year Ended December 31,		
	2011	2012	2013
Continuing operations:(1)			
Number of hospitals	11	11	11
Licensed beds(2)	1,459	1,504	1,504
Admissions(3)	41,471	43,713	42,086
Adjusted admissions(4)	90,037	91,770	90,207
Revenue per adjusted admission	\$ 7,234	\$ 7,827	\$ 8,007
Inpatient surgeries	9,642	9,733	9,504
Outpatient surgeries(5)	20,418	22,074	22,876
Emergency room visits(6)	191,665	219,519	218,251

- (1) Excludes all operations included in discontinued operations.
- (2) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency regardless of actual use.
- (3) Represents the total number of patients admitted to our hospitals and used by management and investors as a general measure of inpatient volume.
- (4) Adjusted admissions are used as a general measure of combined inpatient and outpatient volume. We compute adjusted admissions by multiplying admissions by the outpatient factor (the sum of gross inpatient revenue and gross outpatient revenue and then dividing the result by gross inpatient revenue).
- (5) Outpatient surgeries are surgeries and invasive procedures that do not require admission to our hospitals.
- (6) Represents the total number of hospital-based emergency room visits.

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Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

The following discussion and analysis of financial condition and results of operations should be read in conjunction with our audited consolidated financial statements, the notes to our audited consolidated financial statements, and the other financial information appearing elsewhere in this report. We intend for this discussion to provide you with information that will assist you in understanding our financial statements, the changes in certain key items in those financial statements from year to year, and the primary factors that accounted for those changes. It includes the following sections:

- Forward Looking Statements;
- Executive Overview;
- Critical Accounting Policies;
- Results of Operations Summary; and
- Liquidity and Capital Resources.

FORWARD LOOKING STATEMENTS

This report and other materials the Company has filed or may file with the SEC, as well as information included in oral statements or other written statements made, or to be made, by executive management of the Company, contain, or will contain, disclosures that are "forward-looking statements," which are intended to be covered by the safe harbors created by federal securities laws. Forward-looking statements are those statements that are based upon management's current plans and expectations as opposed to historical and current facts and are often identified in this discussion by use of words including but not limited to "may," "believe," "will," "should," "expect," "estimate," "anticipate," "intend," and "plan." These statements are based upon estimates and assumptions made by Capella's management that, although believed to be reasonable, are subject to numerous factors, risks and uncertainties that could cause actual outcomes and results to be materially different from those projected. Except as required by law, we undertake no obligation to update publicly or to revise any forward-looking statements, whether as a result of new information, future events or otherwise.

In this report, for example, we make forward-looking statements, including statements discussing our expectations about: our business strategy and operating philosophy, including efforts to provide high quality patient care and service excellence, investments in technology, recruitment and retention of physicians and nurses, expansion of service lines, and growth strategies for existing markets and for potential acquisitions; future financial performance and condition; industry and general economic trends, including the impact of the current economic environment, changes to reimbursement, patient volumes and related revenue; our compliance with new and existing laws and regulations, such as the Affordable Care Act, as well as costs and benefits associated with compliance; effects of competition and consolidation on our hospitals' markets; costs of providing care to our patients; the provision for bad debt and the impact of bad debt expenses, including increasing collection risks; future liquidity and capital resources; and existing and future debt.

There are several factors, some beyond our control that could cause results to differ significantly from our expectations. Some of these factors are described in "Part I, Item 1A. Risk Factors." Other factors, such as market, operational, liquidity, interest rate and other risks, are described elsewhere in this section and "Part II, Item 7A. Quantitative and Qualitative Disclosures about Market Risk." Any factor described in this report could by itself, or together with one or more factors, adversely affect our business, results of operations and/or financial condition. There may be factors not described in this report that could also cause results to differ from our expectations. We operate in a continually changing business environment, and new risk factors emerge from time to time. We cannot predict such new risk factors nor can we assess the impact, if any, of such new risk factors on our business or the extent to which any factor or combination of factors may cause actual results to differ materially from those expressed or implied by any forward-looking statements.

EXECUTIVE OVERVIEW

We are a provider of general and specialized acute care, outpatient and other medically necessary services in our primarily non-urban communities. We provide these services through a portfolio of acute care hospitals and complementary outpatient facilities and clinics. As of December 31, 2013, as part of continuing operations, we operated 11 acute care hospitals (ten of which we own and one of which we lease pursuant to a long-term lease) comprised of 1,504 licensed beds in six states. We are

focused on enabling our facilities to maximize their potential to deliver high quality care in a patient-friendly environment. We invest our financial and operational resources to establish and support services that meet the needs of our communities. We seek to achieve our objectives by providing exceptional quality care to our patients, establishing strong local management teams, physician leadership groups and hospital boards, developing deep physician and employee relationships and working closely with our communities.

During the year, the Company experienced increases in self-pay volume and related self-pay gross revenues. The Company believes this trend reflects an increased collection risk from both self-pay accounts aged greater than 360 days as well as an increase in patient co-payments and deductibles, which, as a result, necessitated a review and analysis of the methodology used to determine the

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Company's allowance for doubtful accounts. The Company uses a number of tests to determine the appropriate allowance for doubtful accounts. The allowance is based on the Company's assessment of historical and expected net collections, business and economic conditions, trends in federal, state, private employer healthcare coverage, the impact of recent acquisitions and dispositions, and other collection indicators. Accounts written off as uncollectable are deducted from the allowance for doubtful accounts and subsequent recoveries are added. The provision for doubtful accounts and the allowance for doubtful accounts relate primarily to uninsured amounts (including copayment and deductible amounts from patients) due directly from patients. We also rely on certain analytical tools, including (i) historical trended cash collections compared to net revenue less bad debt; (ii) total bad debt expense, charity care deductions and uninsured discounts as a percentage of self-pay revenue; (iii) net days in accounts receivable; and (iv) the allowance from doubtful accounts as a percentage of total self-pay accounts receivable. Adverse changes in general economic conditions, billing and collections operations, payor mix, or trends in federal or state governmental healthcare coverage could affect our collection of accounts receivable, cash flows and results of operations. As a result of the Company's analysis, management elected to increase the uncollectible percentage for all accounts receivable aged greater than 360 days to a conservative 100%, thereby fully reserving for all accounts receivable greater than 360 days regardless of payor source. The effect of this election was to increase provision for bad debts by an additional \$4.5 million. The Company believes the increase in the uncollectible percentage reflects changes in payor mix and collection patterns.

Trends and Developments

The following sections discuss recent trends and developments that we believe impact our current and/or future operating results and cash flows. Certain of these trends and developments apply to the entire hospital industry, while others may apply to us more specifically. These trends and developments could be short-term in nature or could require long-term attention and resources. While these trends and developments may involve certain factors that are outside of our control, the extent to which these trends and developments affect our hospitals and our ability to manage the impact of these trends and developments play vital roles in our current and future success. In many cases, we are unable to predict what impact, if any, these trends and developments will have on us.

Impact of Healthcare Reform

The Affordable Care Act dramatically altered the United States healthcare system and is intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare. The Affordable Care Act attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance, expanding Medicare and Medicaid eligibility, reducing Medicare DSH and Medicaid payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, bundling payments to hospitals and other providers, and instituting certain private health insurance reforms. Although some of the measures contained in the Affordable Care Act did not take effect until 2014, certain of the reductions in Medicare spending, such as negative adjustments to the Medicare hospital inpatient and outpatient prospective payment system market basket updates and the incorporation of productivity adjustments to the Medicare program's annual inflation updates, became effective in prior years. A number of provisions of the Affordable Care Act that were supposed to become effective in 2014, such as the employer mandate, the Small Business Health Option Program, and the state run exchange verification of income and Medicaid agency electronic notification of eligibility for tax credit and subsidy requirements, have been delayed until 2015 and additional delays could be imposed in the future. On June 28, 2012, the United States Supreme Court upheld the "individual mandate" provision of the Affordable Care Act that generally requires all individuals to obtain healthcare insurance or pay a penalty. The Supreme Court also held, however, that the provision of the Act that authorized the Secretary of HHS to penalize states that choose not to participate in the expansion of the Medicaid program by removing all existing Medicaid funding was unconstitutional. In response to the ruling, a number of states have already indicated that they will not expand their Medicaid programs. Doing so would result in the Affordable Care Act not providing coverage to some low-income persons in those states. Additionally, several bills have been and will likely continue to be introduced in Congress to repeal or amend all or significant provisions of the Affordable Care Act. It is difficult to predict the full impact of the Affordable Care Act because of its complexity, lack of implementing regulations and interpretive guidance, state decisions to decline Medicaid expansion, gradual and potentially delayed implementation, future potential legal challenges, and possible repeal and/or amendment, as well as the inability to foresee how individuals and businesses will respond to the choices afforded them by the Affordable Care Act. As a result, it is difficult to predict the full impact that the Affordable Care Act will have on our revenue and results of operations.

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Adoption of Electronic Health Records

The HITECH Act includes provisions designed to increase the use of EHR by both physicians and hospitals. We intend to comply with the EHR meaningful use requirements of the HITECH Act in time to qualify for the maximum available Medicare and Medicaid incentive payments. We will recognize income related to the Medicare or Medicaid incentive payments as we are able to satisfy all appropriate contingencies, which includes completing attestations as to our eligible hospitals adopting, implementing or demonstrating meaningful use of certified EHR technology, and additionally for Medicare incentive payments, deferring income until the related Medicare fiscal year has passed and cost report information used to determine the final amount of reimbursement is known. Our compliance has resulted in significant costs including professional services focused on successfully designing and implementing our EHR solutions along with costs associated with the hardware and software components of the project. During the years ended December 31, 2011, 2012 and 2013, we recognized \$7.2 million, \$6.4 million and \$12.6 million, respectively, of other income related to estimated EHR incentive payments.

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Medicare and Medicaid Reimbursement

Medicare payment methodologies have been, and are expected to be, significantly revised based on cost containment and policy considerations. CMS has already begun to implement some of the Medicare reimbursement reductions required by the Affordable Care Act. These revisions will likely be more frequent and significant as more of the Affordable Care Act's changes and cost-saving measures become effective. Additionally, the Middle Class Tax Relief and Job Creation Act of 2012 and ATRA require further reductions in Medicare payments, and the BCA imposed a 2% reduction in Medicare spending effective as of April 1, 2013.

In addition, many states in which we operate are facing budgetary challenges and have adopted, or may be considering, legislation that is intended to control or reduce Medicaid expenditures, enroll Medicaid recipients in managed care programs, and/or impose additional taxes on hospitals to help finance or expand their Medicaid programs. Budget cuts, federal or state legislation, or other changes in the administration or interpretation of government health programs by government agencies or contracted managed care organizations could have a material adverse effect on our financial position and results of operations.

Pay for Performance Reimbursement

Many payors, including Medicare and several large managed care organizations, currently require hospital providers to report certain quality measures in order to receive the full amount of payment increases that were awarded automatically in the past. Many large managed care organizations have developed quality measurement criteria that are similar to or even more stringent than these Medicare requirements. While current Medicare guidelines and contracts with most managed care payors provide for reimbursement based upon the reporting of quality measures, we believe significant payors will utilize the quality measures to determine reimbursement rates for hospital services. We have developed key processes and infrastructure that we believe enable us to meet or exceed the current established quality guidelines. We plan to continue to invest in quality initiatives and technology in order to meet the quality demands of our payors in the future.

Value-Based Reimbursement

The trend in the healthcare industry continues towards value-based purchasing of healthcare services. These value-based purchasing programs include both public reporting and financial incentives tied to the quality and efficiency of care provided by facilities. The Affordable Care Act expands the use of value based purchasing initiatives in federal healthcare programs. We expect programs of this type to become more common in the healthcare industry.

Medicare requires providers to report certain quality measures in order to receive full reimbursement increases for inpatient and outpatient procedures that previously were awarded automatically. Historically, CMS has expanded, through a series of rulemakings, the number of patient care indicators that hospitals must report. Additionally, we anticipate that CMS will continue to expand the number of inpatient and outpatient quality measures. We have invested significant capital and resources in the implementation of our advanced clinical system that assists us in monitoring and reporting these quality measures. CMS makes the data submitted by hospitals, including our hospitals, public on its website.

The Affordable Care Act requires the Department to implement a value-based purchasing program for inpatient hospital services. Beginning in federal fiscal year 2013, the Department reduced inpatient hospital payments for all discharges by a percentage specified by statute and pooled the total amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by the Department. CMS evaluates hospitals' performance during a performance period and hospitals will receive points on each of a number of pre-determined measures based on the higher of (i) their level of achievement relative to an established standard or (ii) their improvement in performance from their performance during a prior baseline period. Each hospital's combined scores on all the measures will be translated into value-based incentive payments beginning with inpatient discharges occurring on or after October 1, 2012. In addition, the Affordable Care Act contains a number of other provisions that further tie reimbursement to quality and efficiency. For the FFY 2016 hospital value-based purchasing program, CMS finalized removing these measures and adding four measures. Also beginning in FFY 2013, hospitals that have "excess readmissions" for specified conditions receive reduced reimbursement. Each hospital's performance is publicly reported, and HHS has the discretion to determine terms and conditions of the program such as what "excessive readmissions" means. Medicare also no longer pays hospitals additional amounts for the treatment of certain hospital-acquired conditions, also known as HACs, unless the conditions were present at admission. Further, beginning

in FFY 2015, hospitals that rank in the worst 25% of all hospitals nationally for HACs in the previous year will receive reduced Medicare reimbursements. The FFY 2014 IPPS final rule finalizes the scoring methodology and quality measures that will be used to determine the quartile, as well as the processes, hospitals will use to review and correct their data. The Affordable Care Act also prohibits the use of federal funds under the Medicaid program to reimburse providers for treating certain provider-preventable conditions.

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The Affordable Care Act also requires HHS to implement a value-based purchasing program for inpatient hospital services. The Affordable Care Act requires HHS to reduce inpatient hospital payments for all discharges by a percentage beginning at 1.0% in FFY 2013 and increasing by 0.25% each fiscal year up to 2.0% in FFY 2017 and subsequent years. HHS will pool the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by HHS. HHS will determine the amount each hospital that meets or exceeds the quality performance standards will receive from the pool of dollars created by these payment reductions.

Physician Alignment

Our ability to attract skilled physicians to our hospitals is critical to our success. Coordination of care and alignment of care strategies between hospitals and physicians will become more critical as reimbursement becomes more episode-based. We have physician recruitment goals with primary emphasis on recruiting physicians specializing in family practice, internal medicine, general surgery, oncology, obstetrics and gynecology, cardiology, neurology, orthopedics, urology, otolaryngology and inpatient hospital care (hospitalists). To provide our patients access to the appropriate physician resources, we actively recruit physicians to the communities served by our hospitals through employment agreements, relocation agreements or physician practice acquisitions. We invest in the infrastructure necessary to coordinate our physician alignment strategies and manage our physician operations. The costs associated with recruiting, integrating and managing a large number of new physicians will have a negative impact on our operating results and cash flows in the near term. However, we expect to realize improved clinical quality and service expansion capabilities from this initiative that will impact our operating results positively over the long term.

Physician services are reimbursed under the Medicare physician fee schedule, or PFS, system, under which CMS has assigned a national RVU to most medical procedures and services that reflects the various resources required by a physician to provide the services relative to all other services. Each RVU is calculated based on a combination of work required in terms of time and intensity of effort for the service, practice expense (overhead) attributable to the service and malpractice insurance expense attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs then aggregated. The aggregated amount is multiplied by a conversion factor that accounts for inflation and targeted growth in Medicare expenditures (as calculated by the SGR) to arrive at the payment amount for each service.

The PFS rates are adjusted each year, and reductions in both current and future payments are anticipated. The SGR formula has resulted in payment decreases to physicians every year since 2002. However, all but one of those payment decreases has been averted by Congressional action. For CY 2014, CMS issued a final rule that would have applied the SGR and resulted in an aggregate reduction of 20.1% to all physician payments under the PFS for CY 2014. The Pathway Act delayed application of the SGR and provided for a 0.5% increase in PFS payment rates through March 31, 2014. We cannot predict whether Congress will pass legislation, such as the SGR Repeal Act, to avert the rate cut for the remainder of CY 2014 or will otherwise adopt a permanent fix for the issues that are created by the application of the SGR. If the payment reduction contained in the proposed rule is not averted, the reimbursement received by our employed physicians, the physicians to whom our hospitals have provided recruitment assistance, and the physician members of our medical staffs would be adversely affected.

Cost Pressures

In order to demonstrate a highly reliable environment of care, we must hire and retain nurses who share our ideals and beliefs with respect to delivering high quality patient care and who have access to the training necessary to implement our clinical quality initiatives. While the national nursing shortage has abated somewhat during the last year, the nursing workforce remains volatile. As a result, we expect continuing pressures on nursing salaries and benefits. These pressures include base wage increases, demands for flexible working hours and other increased benefits as well as higher nurse-to-patient ratios. In addition, inflationary pressures and technological advancements and increased acuity continue to drive supply costs higher. We implemented multiple supply chain initiatives, including consolidation of low-priced vendors, established value analysis teams and coordinated quality of care efforts to encourage group purchasing contract compliance.

Uncompensated Care

Like others in the hospital industry, we continue to experience high levels of uncompensated care, including self-pay

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patients, charity care and bad debts. These elevated levels are driven by the number of uninsured and under-insured patients seeking care at our hospitals, the increased acuity levels at which these patients are presenting for treatment, primarily resulting from economic pressures and their related decisions to defer care, increasing healthcare costs and other factors beyond our control, such as increases in the amount of co-payments and deductibles as employers continue to pass more of these costs on to their employees. In addition, as a result of high unemployment and its continued impact on the economy, we believe that our hospitals may continue to experience high levels of or possibly growth in bad debts, self-pay, and charity care. All of these items lead to increased collection risk for our accounts receivable. During the year ended December 31, 2013, our uncompensated care as a percentage of revenue, which includes the impact of uninsured discounts and charity care, was 23.6%, compared to 21.8% in the prior year.

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We anticipate that if we experience further growth in uninsured volume and revenue over the near-term, including increased acuity levels and continued increases in co-payments and deductibles for insured patients, our uncompensated care will increase, our risk of accounts receivable collections will escalate, and our results of operations could be adversely affected.

Similar to others in the hospital industry, we have a significant amount of self-pay receivables (including co-payments and deductibles from insured patients), and collecting these receivables may become more difficult if economic conditions worsen. The following table provides a summary of our accounts receivable payor class mix as of December 31, 2012 and 2013:

<u>December 31, 2012</u>	<u>0-90 Days</u>	<u>91-180 Days</u>	<u>Over 180 Days</u>	<u>Total</u>
Medicare(1)	26.5%	0.8%	0.5%	27.8%
Medicaid(1)	6.1	0.6	0.5	7.2
Managed Care and Other	18.2	1.8	0.6	20.6
Self-Pay(2)	11.4	9.7	23.3	44.4
Total	<u>62.2%</u>	<u>12.9%</u>	<u>24.9%</u>	<u>100.0%</u>
 <u>December 31, 2013</u>	 <u>0-90 Days</u>	 <u>91-180 Days</u>	 <u>Over 180 Days</u>	 <u>Total</u>
Medicare(1)	26.7%	1.0%	1.6%	29.3%
Medicaid(1)	6.7	0.7	0.6	8.0
Managed Care and Other	19.6	1.6	1.2	22.4
Self-Pay(2)	9.5	9.1	21.7	40.3
Total	<u>62.5%</u>	<u>12.4%</u>	<u>25.1%</u>	<u>100.0%</u>

- (1) Includes receivables under managed Medicare or managed Medicaid programs.
 (2) Includes both uninsured as well as estimated co-payment and deductible amounts from insured patients.

The volume of self-pay accounts receivable remains sensitive to a combination of factors, including price increases, acuity of services, higher levels of insured patient co-payments and deductibles, economic factors and the increased difficulties of uninsured patients who do not qualify for charity care programs to pay for escalating healthcare costs. We have implemented a number of practices to mitigate bad debt expense and increase collections, including our uninsured discount program, increased focus on upfront cash collections, incentive plans for our hospitals' financial counselors and registration personnel, increased focus on payment plans with non-emergent patients, among other efforts. Despite these practices, we believe bad debts will remain a significant risk for us and the rest of the hospital industry in the near term.

Implementation of Clinical Quality Initiatives

The integral component of responding to each of the challenge areas previously discussed is quality of care. We have implemented many of our expanded clinical quality initiatives and are in the process of implementing several others. These initiatives include the following:

- review of the current CMS quality indicators;
- mock Joint Commission surveys conducted by a third-party;
- implementation of hourly nursing rounds;
- alignment of hospital management incentive compensation with quality and satisfaction indicators;
- feedback from our LPLGs, NPLG, and PAG;
- hospital board and medical staff oversight of patient safety and quality of care;
- patient discharge callbacks; and
- investment in clinical technology.

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Revenue/Volume Trends

Our revenue depends upon inpatient occupancy levels, outpatient procedures, ancillary services and therapy programs as well as our ability to negotiate appropriate payment rates for services with third-party payors and our ability to achieve quality metrics to maximize payment from our payors.

The primary sources of our revenue before the provision for bad debts include various managed care payors, including managed Medicare and managed Medicaid programs, the traditional Medicare program, various state Medicaid programs, commercial health plans and patients themselves. We are typically paid less than our gross charges, regardless of the payor source, and report revenue before the provision for bad debts to reflect contractual adjustments and other allowances required by managed care providers and federal and state agencies.

Revenue for the year ended December 31, 2013, increased 0.6% to \$722.3 million, compared to \$718.2 million in the prior year.

Revenue for the year ended December 31, 2013 was impacted by the CMS' release of updated Supplemental Security Income ("SSI") percentages for the fiscal year ended December 31, 2011. As a result of the updated SSI percentages, we recorded a reduction to revenue during the year ended December 31, 2013 of approximately \$1.4 million. Revenue for the year ended December 31, 2013 also was impacted by the BCA that was signed on August 2, 2011. The BCA resulted in automatic spending cuts across government programs, including a 2% reduction in Medicare spending. The automatic spending cuts, known as "sequestration", began April 2013. For the year ended December 31, 2013, sequestration negatively impacted our revenue by approximately \$4.6 million. Revenue for the year ended December 31, 2013 was also impacted negatively by the "two midnight rule" that went into effect on October 1, 2013. We estimate the negative impact at \$1.2 million.

Revenue for the year ended December 31, 2013 was also impacted by the Company's election to increase the uncollectible percentage for all accounts receivable aged greater than 360 days to a conservative 100%, thereby fully reserving for all accounts receivable regardless of payor sources. The effect of this election was to increase provision for bad debts by an additional \$4.5 million.

The year ended December 31, 2012 included approximately \$7.0 million of out of period revenue related to the State of Oklahoma's Supplemental Hospital Offset Payment Program, or SHOPP, in which our Oklahoma hospitals participate. SHOPP allows for the establishment of a hospital provider fee assessment on all non-exempt Oklahoma hospitals. Revenue from this assessment is used to maintain hospital reimbursement from the SoonerCare Medicaid program and to secure additional matching Medicaid funds from the federal government. On January 17, 2012, CMS approved SHOPP with an effective date of July 1, 2011. Based on the approval date of January 17, 2012, we recorded the \$7.0 million of revenue related to SHOPP from July 1, 2011 through December 31, 2011 during the year ended December 31, 2012. This approval was necessary to meet the revenue recognition criterion that persuasive evidence of an arrangement exists, pursuant to generally accepted accounting principles.

The year ended December 31, 2012, also included approximately \$6.6 million of revenue related to the industry-wide rural floor provision settlement litigation. The Balanced Budget Act of 1997, or BBA, established a rural floor provision, by which an urban hospital's wage index within a particular state could not be lower than the statewide rural wage index. The wage index reflects the relative hospital wage level compared to the applicable average hospital wage level. The BBA also made this provision budget neutral, meaning that total wage index payments nationwide before and after the implementation of this provision must remain the same. To accomplish this, CMS was required to increase the wage index for all affected urban hospitals and to calculate a rural floor budget neutrality adjustment to reduce other wage indexes in order to maintain the same level of payments. Litigation had been pending for several years contending that CMS miscalculated the neutrality adjustment from 1999 through 2011. The litigation was settled effective April 5, 2012.

Excluding the approximately \$13.6 million of revenue related to both SHOPP and the rural floor settlement described above, our revenue for the year ended December 31, 2013 increased \$17.7 million, or 2.5%, compared to the prior year period.

Admissions and adjusted admissions decreased 3.7% and 1.7%, respectively, for the year ended December 31, 2013, compared to the prior year. Inpatient surgeries decreased 2.4% for the year ended December 31, 2013, compared to the prior

year. Outpatient surgeries increased 3.6% for the year ended December 31, 2013, compared to the prior year. We believe that our increase in outpatient surgeries, along with a decline in same-facility inpatient surgeries, can be attributed to the continuing industry shift from an inpatient hospital setting to an outpatient setting.

We believe our volumes over the long-term will grow as a result of our business strategies, including the continued investment in our physician alignment strategy, increased efforts to promote our commitment to quality and patient satisfaction, and the general aging of the population.

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The following table sets forth the percentages of revenue before the provision for bad debts by payor for the years ended December 31, 2011, 2012 and 2013:

	Year Ended December 31,		
	2011	2012(2)	2013
Medicare(1)	39.2%	39.2%	38.1%
Medicaid(1)	12.8	15.3	14.4
Managed Care and other	37.9	35.3	36.0
Self-Pay	10.1	10.2	11.5
Total	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>

- (1) Includes revenue before the provision for bad debts received under managed Medicare or managed Medicaid programs.
- (2) The increase in Medicaid revenue for fiscal 2012 is due primarily to the Oklahoma Supplemental Hospital Offset Payment Program, or SHOPP. SHOPP increased Medicaid revenue for fiscal 2012 by approximately \$21.5 million.

Revenue per adjusted admission increased 2.3% for the year ended December 31, 2013, compared to the prior year. The change in our revenue per adjusted admissions for the year ended December 31, 2013 was impacted by the prior year revenue recognized from SHOPP and the rural floor provision settlement discussed previously. Excluding the revenue related to SHOPP and the rural floor settlement, our revenue per adjusted admission increased 4.2% for the year ended December 31, 2013, compared to the prior year. The increase in our revenue per adjusted admission is primarily due to an increase in acuity as evidenced by a 5.6% increase in our Medicare case mix index for the year and improvement in our managed care pricing.

CRITICAL ACCOUNTING POLICIES

The preparation of financial statements in accordance with accounting principles generally accepted in the United States requires us to make estimates and assumptions that affect the reported amounts and related disclosures. We consider an accounting estimate to be critical if:

- it requires assumptions to be made that were uncertain at the time the estimate was made; and
- changes in the estimate or different estimates that could have been made could have a material impact on our consolidated results of operations or financial condition.

Revenue and Revenue Deductions

We recognize revenue before the provision for bad debts during the period the healthcare services are provided based upon estimated amounts due from payors. We record contractual adjustments to our gross charges to reflect expected reimbursement negotiated with or prescribed by third-party payors. We estimate contractual adjustments and allowances based upon payment terms set forth in managed care health plan contracts and by federal and state regulations. For the majority of our revenue before the provision for bad debts, we apply contractual adjustments to patient accounts at the time of billing using specific payor contract terms entered into the accounts receivable systems, but in some cases we record an estimated allowance until payment is received. If our estimated contractual adjustments as a percentage of gross revenue had been 1% higher for all insured accounts, our revenue before the provision for bad debts would have been reduced by approximately \$28.4 million, \$31.6 million and \$32.7 million for the years ended December 31, 2011, 2012 and 2013, respectively. We derive most of our revenue before the provision for bad debts from healthcare services provided to patients with Medicare (including managed Medicare plans) or managed care insurance coverage.

Services provided to Medicare patients are generally reimbursed at prospectively determined rates per diagnosis, while services provided to managed care patients are generally reimbursed based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Medicaid reimbursements vary by state. Other than Medicare and Medicaid, no individual payor represents more than 10% of our revenue.

Medicare regulations and many of our managed care contracts are often complex and may include multiple reimbursement mechanisms for different types of services provided in our healthcare facilities. To obtain reimbursement for certain services under the Medicare program, we must submit annual cost reports and record estimates of amounts owed to or receivable from

Medicare. These cost reports include complex calculations and estimates related to indirect medical education, disproportionate share payments, reimbursable Medicare bad debts and other items that are often subject to interpretation that could result in payments that differ from recorded estimates. We estimate amounts owed to or receivable from the Medicare program using the best information available and our interpretation of the applicable Medicare regulations. We include differences between original estimates and subsequent revisions to those estimates (including final cost report settlements) in our consolidated statements of operations in the period in which the revisions are made.

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Net adjustments for the final third-party settlements decreased revenue and income from continuing operations before income taxes by \$0.2 million during the year ended December 31, 2011, and increased revenue and income from continuing operations by \$1.1 million and \$0.3 million during the years ended December 31, 2012 and 2013, respectively. Additionally, updated regulations and contract negotiations with payors occur frequently, which necessitates continual review of revenue estimation processes by management. Management believes that future adjustments to its current third-party settlement estimates will not materially impact our results of operations, cash flows or financial position.

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (generally it is those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by HHS). We deduct charity care accounts from net revenue when we determine that the account meets our charity care guidelines. We also provide discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. For the years ended December 31, 2011, 2012 and 2013, we estimate that our cost of care provided under our charity care programs were approximately \$2.9 million, \$3.4 million and \$2.8 million, respectively.

Insurance Reserves

We are self-insured for substantially all of the medical expenses and benefits of our employees. Our reserve for employee medical benefits primarily reflects the current estimate of incurred but not reported losses, based upon an actuarial calculation.

Given the nature of our operating environment, we are subject to potential medical malpractice lawsuits and other claims as part of providing healthcare services. To mitigate a portion of this risk, we maintain insurance through Auriga in sufficient amounts for malpractice claims, subject to a self-insured retention per occurrence. Auriga has re-insurance for malpractice claims which cover additional amounts in the aggregate. Our reserves for professional and general liability claims are based upon independent actuarial calculations, which consider historical claims data, demographic considerations, severity factors and other actuarial assumptions in determining reserve estimates. Our reserve estimates are discounted to present value using a 1% discount rate.

We are also subject to potential workers' compensation claims as part of providing healthcare services. To mitigate a portion of this risk, we maintain insurance for individual workers' compensation claims exceeding approximately \$250,000 per occurrence. Our hospital facility located in the State of Washington and our two facilities located in Oklahoma participate in state-specific programs rather than our established program. Our reserve for workers' compensation is based upon an independent third-party actuarial calculation, which considers historical claims data, demographic considerations, development patterns, severity factors and other actuarial assumptions. Our reserve estimates are undiscounted and are revised on an annual basis. Our reserve for workers' compensation claims reflects the current estimate of all outstanding losses, including incurred but not reported losses, based upon an actuarial calculation.

Our expense for professional and general liability claims and workers' compensation claims each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported ("IBNR"); the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; amortization of the insurance premiums for losses in excess of our self-insured retention level; the administrative costs of the insurance program; and interest expense related to the discounted portion of the liability.

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The following tables summarize our claims loss and claims payment information during the years ended December 31, 2011, 2012 and 2013 and our professional and general liability reserve balances (including the current portions of such reserves, but excluding amounts recoverable from Auriga and third-party insurers) as of December 31, 2012 and 2013.

	Year Ended December 31,		
	2011	2012	2013
	(In millions)		
Accrual for general and professional liability claims at January 1	\$ 12.4	\$ 12.7	\$ 12.7
Expense (income) related to(1):			
Current accident year	4.5	4.6	6.8
Prior accident years	(2.5)	(2.3)	(4.0)
Total incurred loss and loss expense	<u>2.0</u>	<u>2.3</u>	<u>2.8</u>
Paid claims and expenses related to:			
Current accident year	0.2	0.3	0.2
Prior accident years	1.5	2.0	3.1
Total paid claims and expense	<u>1.7</u>	<u>2.3</u>	<u>3.3</u>
Accrual for general and professional liability claims at December 31	<u>\$ 12.7</u>	<u>\$ 12.7</u>	<u>\$ 12.2</u>

- (1) Total expense, including premiums for insured coverage, was \$5.6 million, \$6.3 million and \$7.5 million for the years ended December 31, 2011, 2012 and 2013, respectively.

Our estimate of professional and general liability and workers' compensation IBNR utilizes statistical confidence levels that are below 75%. Using a higher statistical confidence level, while not permitted under GAAP, would increase the estimated reserve. The following table illustrates the sensitivity at reserve estimates at 75% and 90% confidence levels:

	Professional and General Liability	Workers' Compensation
	(In millions)	
December 31, 2012 reserve:		
As reported	\$ 12.7	\$ 3.4
With 75% confidence level	14.9	4.0
With 90% confidence level	18.3	5.0
December 31, 2013 reserve:		
As reported	\$ 12.2	\$ 3.7
With 75% confidence level	14.5	4.3
With 90% confidence level	18.3	5.2

If our estimate of the number of unpaid days of employee health claims expense changed by five days, our employee health IBNR estimate would change by approximately \$0.5 million.

Income Taxes

We believe that our income tax provisions are accurate and supportable, but certain tax matters require interpretations of tax law that may be subject to future challenge and may not be upheld under tax audit. To reflect the possibility that all of our tax positions may not be sustained, we maintain tax reserves that are subject to adjustment as updated information becomes available or as circumstances change. We record the impact of tax reserve changes to our income tax provision in the period in which the additional information, including the progress of tax audits, is obtained.

We assess the realization of our deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be verified objectively, we determine whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The factors used in this determination include the following:

- cumulative losses in recent years;

- income/losses expected in future years;
- unsettled circumstances that, if favorably resolved, would adversely affect future operations;
- availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits;
- carryforward period associated with the deferred tax assets and liabilities; and
- prudent and feasible tax planning strategies.

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In addition, financial forecasts used in determining the need for or amount of federal and state valuation allowances are subject to changes in underlying assumptions and fluctuations in market conditions that could significantly alter our recoverability analysis and thus have a material adverse effect on our consolidated financial condition, results of operations or cash flows. We follow the provisions of Financial Accounting Standards Board ("FASB") authoritative guidance regarding income tax uncertainties. No tax adjustment was required upon adoption of this authoritative guidance. Under these provisions, we elected to classify interest paid on an underpayment of income taxes and related penalties as a component of income tax expense.

Long-Lived Assets and Goodwill

Long-lived assets, including property, plant and equipment and amortizable intangible assets, comprise a significant portion of our total assets. We evaluate the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist under the provisions of FASB authoritative guidance regarding the impairment or disposal of long-lived assets. When management believes impairment indicators may exist, projections of the undiscounted future cash flows associated with the use of and eventual disposition of long-lived assets held for use are prepared. If the projections indicate that the carrying values of the long-lived assets are not recoverable, we reduce the carrying values to fair value. These impairment tests are heavily influenced by assumptions and estimates that are subject to change as additional information becomes available. Given the relatively few number of hospitals we own and the significant amounts of long-lived assets attributable to those hospitals, an impairment of the long-lived assets could materially adversely impact our operating results or financial position.

Goodwill also represents a significant portion of our total assets. We review goodwill for impairment annually at October 1 or more frequently if certain impairment indicators arise under the provisions of FASB authoritative guidance regarding goodwill and other intangible assets. Our business comprises a single reporting unit for impairment of goodwill. We compare our carrying value of the consolidated net assets to the estimated fair value based primarily on net present value of our estimated discounted future cash flows. If the carrying value exceeds fair value an impairment indicator exists and an estimate of the impairment loss is calculated. The fair value calculation includes multiple assumptions and estimates, including the projected cash flows and discount rates applied. Changes in these assumptions and estimates could result in goodwill impairment that could materially adversely impact our financial position or results of operations.

We did not incur any impairment charges, other than with respect to discontinued operations, during the years ended December 31, 2011, 2012 or 2013.

Allowance for Doubtful Accounts and Provision for Bad Debts

Our ability to collect the self-pay portion of our receivables is critical to our operating performance and cash flows. Our allowance for doubtful accounts was approximately 79% and 89% of self-pay accounts receivable, net of contractual discounts, as of December 31, 2012 and December 31, 2013, respectively. Our additions to the allowance for doubtful accounts are made by means of the provision for doubtful accounts. Accounts written off as uncollectable are deducted from the allowance for doubtful accounts and subsequent recoveries are added. During the year, the Company experienced increases in self-pay volume and related self-pay gross revenues. The Company believes this trend reflects an increased collection risk from both aged self-pay accounts greater than 360 days old, as well as an increase in patient co-payments and deductibles.

As a result of an internal review, we elected to increase the uncollectible percentage for all accounts receivable greater than 360 days to a conservative 100%, thereby fully reserving for all accounts receivable regardless of payor resources. The effect of this review was to increase provision for bad debts by an additional \$4.5 million.

The Company uses a number of tests to determine the appropriate allowance for doubtful accounts. The allowance is based on the Company's assessment of historical and expected net collections, business and economic conditions, trends in federal, state, and private employer healthcare coverage, the impact of recent acquisitions or dispositions, and other collection indicators. Accounts written off as uncollectable are deducted from the allowance for doubtful accounts and subsequent recoveries are added. The provision for doubtful accounts and the allowance for doubtful accounts relate primarily to uninsured amounts (including copayment and deductible amounts from patients) due directly from patients. We also rely on certain analytical tools, including (i) historical trended cash collections compared to net revenue less bad debt; (ii) total bad

debt expense, charity care deductions and uninsured discounts as a percentage of self-pay revenue; (iii) net days in accounts receivable; and (iv) the allowance from doubtful accounts as a percentage of total self-pay accounts receivable. Adverse changes in general economic conditions, billing and collections operations, payor mix, or trends in federal or state governmental healthcare coverage could affect our collection of accounts receivable, cash flows and results of operations. If our uninsured accounts receivable as of December 31, 2013 were 1% higher, our provision for doubtful accounts would have increased by \$1.1 million.

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Effective January 1, 2011, we adopted a uniform uninsured discount policy. Generally, under this policy, patients without insurance are provided a 60% discount from gross charges at the time of billing. The discount is reflected as a deduction from revenue in the determination of revenue before provision for bad debts. The amount billed to the patient is subject to our customary collection process and, to the extent not collected, becomes subject to our policy governing our bad debt provision.

Table of Contents**RESULTS OF OPERATIONS**

The following table presents summaries of results of operations for the three years ended December 31, 2011, 2012 and 2013.

	Year Ended December 31, 2011		Year Ended December 31, 2012		Year Ended December 31, 2013	
	Amount	Percentage	Amount	Percentage	Amount	Percentage
Revenue before provision for bad debts	\$ 723.7	111.1%	\$ 802.3	111.7%	\$ 828.5	114.7%
Provision for bad debts	(72.3)	(11.1)%	(84.1)	(11.7)%	(106.2)	(14.7)%
Revenue	651.4	100.0%	718.2	100.0%	722.3	100.0%
Costs and expenses:						
Salaries and benefits (includes stock compensation of \$0.8, \$1.0, and \$0.8 respectively)	313.9	48.2%	333.2	46.4%	342.8	47.5%
Supplies	108.3	16.6%	114.8	16.0%	123.1	17.0%
Other operating expenses	144.7	22.2%	177.7	24.7%	185.5	25.7%
Other income	(7.2)	(1.1)%	(6.4)	(0.9)%	(12.6)	(1.7)%
Depreciation and amortization	31.8	4.9%	37.8	5.3%	44.2	6.1%
Interest, net	51.1	7.8%	53.1	7.4%	55.0	7.6%
Management fee to related party	0.2	—	0.2	—	0.2	—
Total costs and expenses	642.8	98.7%	710.4	98.9%	738.2	102.2%
Income (loss) from continuing operations before income taxes	8.6	1.3%	7.8	1.1%	(15.9)	(2.2)%
Income taxes	1.4	0.2%	3.0	0.4%	4.0	0.6%
Income (loss) from continuing operations	7.2	1.1%	4.8	0.6%	(19.9)	(2.8)%
Loss from discontinued operations, net of tax	(20.5)	(3.1)%	(17.6)	(2.4)%	(11.4)	(1.6)%
Net loss	<u>\$ (13.3)</u>	<u>(2.0)%</u>	<u>\$ (12.8)</u>	<u>(1.8)%</u>	<u>\$ (31.3)</u>	<u>(4.3)%</u>
Less: Net income attributable to non-controlling interests	1.2	0.2%	1.3	0.2%	0.5	—
Net loss attributable to Capella Healthcare, Inc.	<u>\$ (14.5)</u>	<u>(2.2)%</u>	<u>\$ (14.1)</u>	<u>(2.0)%</u>	<u>\$ (31.8)</u>	<u>(4.3)%</u>

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Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

Revenue. Revenue for the year ended December 31, 2013 was \$722.3 million, an increase of \$4.1 million, or 0.6%, over the year ended December 31, 2012. Revenue for the year ended December 31, 2012 included approximately \$13.6 million of revenue recorded related to the prior period SHOPP, approved by CMS in January 2012 (from July 1, 2011 to December 31, 2011) and rural floor settlement discussed previously. Excluding the approximately \$13.6 million of revenue related to both SHOPP and the rural floor settlement described above, our revenue for the year ended December 31, 2013 increased \$17.7 million, or 2.5%, compared to the prior year period. The increase in revenue was due to an increase in revenue per adjusted admission of 4.2%, offset by a decline in adjusted admissions of approximately 1.7%.

Our revenue was also impacted by an increase in our provision for bad debts, which increased \$22.1 million, or 26.3% compared to the year ended December 31, 2012. The increase in bad debts was primarily due to the growth in uninsured patient volume and revenue. We continue to experience high levels of uncompensated care and high emergency room self-pay volumes. Self-pay gross revenue increased 8.1% compared to the prior year. The Company believes this trend reflects an increased collection risk from self-pay accounts, and as a result has increased the Company's allowance for doubtful accounts. The Company uses a number of tests to determine the appropriate allowance for doubtful accounts. The allowance is based on the Company's assessment of historical and expected net collections, business and economic conditions, trends in federal, state, and private employer healthcare coverage, the impact of recent acquisitions and disposition, and other collection indicators. Accounts written off as uncollectable are deducted from the allowance for doubtful accounts and subsequent recoveries are added. The provision for doubtful accounts and the allowance for doubtful accounts relate primarily to uninsured amounts (including copayment and deductible amounts from patients) due directly from patients. We also rely on certain analytical tools, including (i) historical trended cash collections compared to net revenue less bad debt; (ii) total bad debt expense, charity care deductions and uninsured discounts as a percentage of self-pay revenue; (iii) net days in accounts receivable; and (iv) the allowance from doubtful accounts as a percentage of total self-pay accounts receivable. Adverse changes in general economic conditions, billing and collections operations, payor mix, or trends in federal or state governmental healthcare coverage could affect our collection of accounts receivable, cash flows and results of operations. As a result of the Company's analysis, management changed the uncollectible percentage for all accounts receivable greater than 360 days to a conservative 100%, thereby fully reserving for all accounts receivable greater than 360 days regardless of payor sources. The result of this change was to increase provision for bad debts by an additional \$4.5 million.

Salaries and benefits. Salaries and benefits for the year ended December 31, 2013 were \$342.8 million, or 47.5% of revenue, compared to \$333.2 million, or 46.4% of revenue, during the year ended December 31, 2012. Our salaries and benefits margin for the year ended December 31, 2012 was impacted by the prior period SHOPP and rural floor settlement revenue discussed previously. Excluding the revenue and expense related to the prior period SHOPP and rural floor settlement, salaries and benefits as a percentage of revenue were 47.0% for the year ended December 31, 2012. The increase in our salaries and benefits margin was due primarily to the slower revenue growth discussed previously. In November 2013, the Company began a plan of restructuring and reorganizing. This plan resulted in the elimination of certain positions within the corporate support center, which resulted in a charge of approximately \$2.9 million in related payments.

Supplies. Supplies expense for the year ended December 31, 2013 was \$123.1 million, or 17.0% of revenue, compared to \$114.8 million, or 16.0%, of revenue for the year ended December 31, 2012. Our supplies margin for the year ended December 31, 2012 was impacted by the SHOPP program and rural floor settlement revenue discussed previously. Excluding revenue related to the prior period SHOPP program and rural floor settlement, supplies expense as a percentage of revenue was 16.3% for the year ended December 31, 2012. The change in our supplies margin was due primarily to an increase in supply intensive inpatient surgical cases and a 3.6% increase in outpatient surgeries, along with the slower revenue growth discussed previously.

Other operating expenses. Other operating expenses include, among other things, professional fees, repairs and maintenance, rents and leases, utilities, insurance, non-income taxes and physician income guarantee amortization.

Other operating expenses for the year ended December 31, 2013 were \$185.5 million, or 25.7% of revenue, compared to \$177.7 million, or 24.7% of revenue for the year ended December 31, 2012. The increase in other operating expenses margin is due to a primarily to an approximate \$7.0 million increase in professional fees and contract services generated by hospitalist programs and new service lines at our facilities.

Other income. Other income includes EHR incentive payments, which represent those incentives under the HITECH Act for which the recognition criteria have been met. For the year ended December 31, 2013, we recognized approximately \$12.6 million of incentive reimbursements, compared to \$6.4 million for the year ended December 31, 2012.

Income taxes. Our effective tax rate from continuing operations was approximately 25.2% for the year ended December 31, 2013 compared to 38.5% for the year ended December 31, 2012. The change in the effective tax rate is driven by changes in the level of pretax income combined with the Company's net deferred tax liability position and related limitations with respect to deferred tax liabilities associated with indefinite-life intangible assets.

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Year Ended December 31, 2012 Compared to Year Ended December 31, 2011

Revenue. Revenue for the year ended December 31, 2012 was \$718.2 million, an increase of \$66.8 million, or 10.3%, over the year ended December 31, 2011. The increase in revenue was due to the following: (i) revenue recorded related to the prior period SHOPP, approved by CMS in January 2012 (from July 1, 2011 to December 31, 2011) and rural floor settlement which contributed approximately \$13.6 million of revenue and (ii) an increase in adjusted admissions of 1.9% and an increase in revenue per adjusted admission (excluding SHOPP revenue related to the period from July 1, 2011 to December 31, 2011 and the rural floor settlement) of approximately 6.1%. Revenue for the year ended December 31, 2012 includes the results of DeKalb Community Hospital and Stones River Hospital for twelve months compared to six months in the prior year.

Our revenue was impacted by an increase in our provision for bad debts, which increased \$11.8 million, or 16.3% compared to the year ended December 31, 2011. The increase in bad debts was primarily due to the growth in uninsured patient volume and revenue. Self-pay admissions were 6.0% of total admissions, which increased from 5.6% during the year ended December 31, 2011. Self-pay gross revenue increased 21.3% compared to the prior year.

Salaries and benefits. Salaries and benefits for the year ended December 31, 2012 were \$333.2 million, or 46.4% of revenue, compared to \$313.9 million, or 48.2% of revenue, during the year ended December 31, 2011. Our salaries and benefits margin was impacted by the prior period SHOPP and rural floor settlement revenue discussed previously. Also, as a result of the rural floor provision settlement, we recorded an additional \$2.2 million in incentive compensation for our employees in accordance with our incentive plan provisions during the year ended December 31, 2012. Excluding the revenue and expense related to the prior period SHOPP and rural floor settlement, salaries and benefits as a percentage of revenue were 47.0% for the year ended December 31, 2012, compared to 48.2% in the prior year. Our salaries and benefits margin benefitted from a \$3.0 million reduction in contract labor and the focus on continued labor productivity improvements across our facilities.

Supplies. Supplies expense for the year ended December 31, 2012 was \$114.8 million, or 16.0% of revenue, compared to \$108.3 million, or 16.6%, of revenue for the year ended December 31, 2011. Our supplies margin was impacted by the SHOPP program and rural floor settlement revenue discussed previously. Excluding revenue related to the prior period SHOPP program and rural floor settlement, supplies expense as a percentage of revenue was 16.3%, compared to 16.6% in the same prior year period. The improvement in our supplies margin was due to our continued efforts to manage supply costs.

Other operating expenses. Other operating expenses include, among other things, professional fees, repairs and maintenance, rents and leases, utilities, insurance, non-income taxes and physician income guarantee amortization.

Other operating expenses for the year ended December 31, 2012 were \$177.7 million, or 24.7% of revenue, compared to \$144.7 million, or 22.2%, of revenue for the year ended December 31, 2011. The increase in other operating expenses margin is due to a \$11.0 million increase in provider taxes and fees, a \$10.7 million increase in contract services from the implementation of new service lines at our facilities, a \$5.1 million increase in professional fees primarily due to the implementation of hospitalist programs at two of our hospitals and a \$3.4 million increase in acquisition costs.

Other income. Other income includes EHR incentive payments, which represent those incentives under the HITECH Act for which the recognition criteria have been met. For the year ended December 31, 2012, we recognized approximately \$6.4 million of incentive reimbursements, compared to \$7.2 million for the year ended December 31, 2011.

Income taxes. Our effective tax rate from continuing operations was approximately 38.5% for the year ended December 31, 2012 compared to 16.3% for the year ended December 31, 2011. The change in the effective tax rate is driven by changes in the level of pretax income combined with the Company's net deferred tax liability position and related limitations with respect to deferred tax liabilities associated with indefinite-life intangible assets.

Table of Contents**LIQUIDITY AND CAPITAL RESOURCES**

The following table shows a summary of our cash flows for the years ended December 30, 2012 and 2013.

	Year Ended December 31,	
	2012	2013
	(In millions)	
Cash provided by operating activities	\$ 44.0	\$ 30.8
Cash used in investing activities	(47.4)	(26.8)
Cash provided used in financing activities	(5.7)	(10.9)

Operating Activities

Cash provided by operating activities was \$44.0 million for the year ended December 31, 2012, compared to \$30.8 million for the year ended December 31, 2013. The prior year period included approximately \$13.6 of cash received related to SHOPP and the rural floor settlement discussed previously.

At December 31, 2013, we had working capital, excluding assets and liabilities held for sale and the current portion of long-term debt of \$82.8 million, including cash and cash equivalents of \$26.4 million, compared to working capital excluding assets held for sale at December 31, 2012 of \$88.0 million, including cash and cash equivalents of \$33.3 million.

Investing Activities

Cash used in investing activities was \$47.4 million for the year ended December 31, 2012 compared to \$26.8 million for the year ended December 31, 2013. In the prior year, we spent approximately \$26.0 million for healthcare business acquisitions. Capital expenditures for the year ended December 31, 2012 were \$32.9 million compared to \$26.3 million for the year ended December 31, 2013. During the year ended December 31, 2013, we spent approximately \$8.7 million on information technology, \$12.6 million on growth capital, with the remainder on routine capital. We also received proceeds of approximately \$1.6 million from the disposition of assets during the year ended December 31, 2013.

Financing Activities

Cash flows used in financing activities was \$5.7 million for the year ended December 31, 2012, compared to cash used in financing activities of \$10.9 million for the year ended December 31, 2013. During the year ended December 31, 2013, we paid approximately \$9.8 million on our capital leases and other obligations, \$1.2 million in distributions to non-controlling interests and \$0.2 million to repurchase non-controlling interests.

The Refinancing

In June 2010, we completed a comprehensive refinancing plan, or the Refinancing. Under the Refinancing, we issued \$500.0 million of the 9 1/4% Senior Unsecured Notes due 2017 (the "9 1/4% Notes") Notes in a private placement offering and entered into a new senior secured asset based loan, or the ABL, consisting of a \$100.0 million revolving credit facility maturing in December 2014, or the 2010 Revolving Facility. The proceeds from the 9 1/4% Notes were used to repay the outstanding principal and interest related to our previous term loan facility and to pay fees and expenses relating to the Refinancing of approximately \$21.7 million.

Effective November 4, 2011, in accordance with a registration rights agreement entered into by us in connection with the private placement offering of the 9 1/4% Notes, we completed the exchange of the 9 1/4% Notes for \$500.0 million in registered 9 1/4% Notes with substantially identical terms as the 9 1/4% Notes. We did not receive any proceeds from this exchange.

Debt Covenants

The indenture governing the 9 1/4% Notes contains a number of covenants that, among other things, restrict, subject to certain exceptions, our ability and the ability of our subsidiaries, to sell assets, incur additional indebtedness or issue preferred stock, pay dividends and distributions or repurchase our capital stock, create liens on assets, make investments, engage in

mergers or consolidations, and engage in certain transactions with affiliates. At December 31, 2012 and 2013, we were in compliance with all debt covenants that were subject to testing at such dates.

Capital Resources

We expect that cash on hand, cash generated from our operations and cash expected to be available to us under the 2010 Revolving Facility will be sufficient to meet our working capital needs and planned capital expenditure programs for the next 12 months and into the foreseeable future. However, we cannot assure you that our operations will generate sufficient cash or that future borrowings under the Refinancing will be available to enable us to meet these requirements.

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We had \$33.3 million and \$26.4 million of cash and cash equivalents as of December 31, 2012 and December 31, 2013, respectively. We rely on available cash, cash flows generated by operations and available borrowing capacity under the 2010 Revolving Facility to fund our operations and capital expenditures. We invest our cash in accounts in high-quality financial institutions. We continually explore various options to increase the return on our invested cash while preserving our principal cash balances. However, the significant majority of our cash and cash equivalents are held in accounts that are not federally-insured and could be at risk in the event of a collapse of the financial institutions at which those accounts are held.

In addition, our liquidity and ability to fund our capital requirements are dependent on our future financial performance, which is subject to general economic, financial and other factors that are beyond our control. If those factors significantly change or other unexpected factors adversely affect us, our business may not generate sufficient cash flows from operations or we may not be able to obtain future financings to meet our liquidity needs. We anticipate that, to the extent additional liquidity is necessary to fund our operations, it would be funded through borrowings under our 2010 Revolving Facility, the incurrence of other indebtedness, additional note issuances or a combination of these potential sources of liquidity. We may not be able to obtain this additional liquidity when needed on terms acceptable to us.

We also intend to continue to pursue acquisitions or partnering arrangements, either in existing markets or new markets, which fit our growth strategies. To finance such transactions, we may draw upon cash on hand, amounts available under our revolving credit facility or seek additional funding sources. We continually assess our capital needs and may seek additional financing, including debt or equity, as considered necessary to fund potential acquisitions, fund capital projects or for other corporate purposes. We may be unable to raise additional equity proceeds from the investment funds affiliated with GTCR, which are our principal investors, or other investors should we need to obtain cash for any of these purposes. Our future operating performance, ability to service our debt and ability to draw upon other sources of capital will be subject to future economic conditions and other business factors, many of which are beyond our control.

As market conditions warrant, we and our major equity holders, including GTCR, may from time-to-time repurchase debt securities issued by us, in privately negotiated or open market transactions, by tender offer or otherwise.

Obligations and Commitments

The following table reflects a summary of obligations and commitments outstanding with payment dates as of December 31, 2013 (in millions):

	Payments Due by Period				Total
	Within 1 Year	During Years 2-3	During Years 4-5	After 5 Years	
Contractual Cash Obligations:					
Long-term debt (1)	\$ 51.4	\$ 92.5	\$ 523.1	\$ —	\$667.0
Operating leases (2)	9.3	13.0	8.1	9.6	40.0
Capital lease obligations, with interest	46.9	8.2	4.1	—	59.2
Estimated self-insurance liabilities (3)	7.0	7.6	3.4	1.3	19.3
Subtotal	<u>\$114.6</u>	<u>\$ 121.3</u>	<u>\$ 538.7</u>	<u>\$ 10.9</u>	<u>\$785.5</u>
Other Commitments:					
Construction and capital improvements (4)	\$ 6.5	\$ —	\$ —	\$ —	\$ 6.5
Letters of credit (5)	4.9	—	—	—	4.9
Physician commitments (6)	3.8	0.7	—	—	4.5
Information technology commitments (7)	7.3	15.3	15.9	8.2	46.7
Subtotal	<u>\$ 22.5</u>	<u>\$ 16.0</u>	<u>\$ 15.9</u>	<u>\$ 8.2</u>	<u>\$ 62.6</u>
Total obligations and commitments	<u>\$137.1</u>	<u>\$ 137.3</u>	<u>\$ 554.6</u>	<u>\$ 19.1</u>	<u>\$848.1</u>

(1) Includes both principal and interest portions of outstanding debt.

(2) These obligations are not reflected in our consolidated balance sheets.

(3) Includes the current and long-term portions of our professional and general liability, workers' compensation and employee health reserves.

- (4) Represents our estimate of amounts we are committed to fund in future periods through executed agreements to complete projects included as construction in progress on our consolidated balance sheets.

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- (5) Amounts relate to instances in which we have letters of credit outstanding with the third party administrators of our self-insured workers' compensation program.
- (6) Includes physician guarantee liabilities recognized on our consolidated balance sheets under FASB provisions regarding minimum revenue guarantees and liabilities for other fixed expenses under physician relocation agreements not yet paid.
- (7) An affiliate of HCA and another third-party vendor provide various information systems services, including but not limited to, financial, clinical, revenue cycle management, patient accounting and network information services, under contracts that expire beginning 2017. The amounts are based on estimated fees that will be charged to our hospitals with an annual fee increase to our hospitals that is capped by the consumer price index increase.

Guarantees and Off-Balance Sheet Arrangements

We are a party to certain master lease agreements and other similar arrangements with non-affiliated entities.

We enter into physician income guarantees and other guarantee arrangements, including parent-subsidary guarantees, in the ordinary course of business. We do not believe we have engaged in any transaction or arrangement with an unconsolidated entity that is reasonably likely to affect liquidity materially.

We do not have any relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. Accordingly, we are not materially exposed to any financing, liquidity, market or credit risk that could arise if we had engaged in such relationships.

Effects of Inflation and Changing Prices

Various federal, state and local laws have been enacted that, in certain cases, limit our ability to increase prices. Revenue for acute hospital services rendered to Medicare patients is established under the federal government's prospective payment system. We believe that hospital industry operating margins have been, and may continue to be, under significant pressure because of changes in payor mix and growth in operating expenses in excess of the increase in prospective payments under the Medicare program. In addition, as a result of increasing regulatory and competitive pressures, our ability to maintain operating margins through price increases to non-Medicare patients is limited.

Table of Contents**Item 7A. Quantitative and Qualitative Disclosures about Market Risk.**

We are subject to market risk from exposure to changes in interest rates based on our financing, investing and cash management activities. As of December 31, 2013, we had no indebtedness outstanding bearing interest at variable rates. Although changes in the alternate base rate or the LIBOR rate would affect the cost of funds borrowed under the 2010 Revolving Facility in the future, we believe the effect, if any, of reasonably possible near-term changes in interest rates would not be material to our results of operations or cash flows.

Item 8. Financial Statements and Supplementary Data.

Information with respect to this Item is contained in our consolidated financial statements beginning on Page F-1 of this report.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure.

We did not experience a change in or disagreement with our accountants during the year ended December 31, 2013.

Item 9A. Controls and Procedures.**Disclosure Controls and Procedures**

We carried out an evaluation, under the supervision and with the participation of management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures as of the end of the period covered by this report pursuant to Rule 15d-15 of the Exchange Act. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective in ensuring that information required to be disclosed by us (including our consolidated subsidiaries) in reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported on a timely basis.

Management's Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting. Internal control over financial reporting is a process to provide reasonable assurance regarding the reliability of our financial reporting in accordance with U.S. generally accepted accounting principles. Our internal control over financial reporting includes a program of internal audits and appropriate reviews by management, written policies and guidelines, careful selection and training of qualified personnel including a dedicated compliance department and a written Code of Conduct adopted by our Board of Directors, applicable to all of our directors, officers and employees.

Internal control over financial reporting includes maintaining records that in reasonable detail accurately and fairly reflect our transactions; providing reasonable assurance that transactions are recorded as necessary for preparation of our financial statements; providing reasonable assurance that receipts and expenditures of company assets are made in accordance with management authorization; and providing reasonable assurance that unauthorized acquisition, use or disposition of company assets that could have a material effect on our financial statements would be prevented or detected in a timely manner. Because of its inherent limitations, including the possibility of human error and the circumvention or overriding of control procedures, internal control over financial reporting is not intended to provide absolute assurance that a misstatement of our financial statements would be prevented or detected. Therefore, even those internal controls determined to be effective can only provide reasonable assurance with respect to financial statement preparation and presentation.

Management conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (1992 Framework). Based on this evaluation, management concluded that our internal control over financial reporting was effective as of December 31, 2013.

This Annual Report does not include an attestation report of our independent registered public accounting firm regarding internal control over financial reporting in reliance on SEC rules that permit us to provide only management's report.

Changes in Internal Control over Financial Reporting

There were no changes in our internal control over financial reporting during the three months ended December 31, 2013 that have affected materially, or are reasonably likely to affect materially, our internal control over financial reporting

Item 9B. Other Information.

In connection with Michael Wiechart's appointment as President and Chief Executive Officer, Mr Wiechart's base salary was increased to \$650,000 as of January 1, 2014. There were no changes to his employment agreement.

Table of Contents**PART III****Item 10. Directors, Executive Officers and Corporate Governance.**

The table below presents information with respect to the members of Capella's Board of Directors and executive officers and their ages.

<u>Name</u>	<u>Age</u>	<u>Position</u>
Michael A. Wiechart	48	President and Chief Executive Officer
D. Andrew Slusser	54	Executive Vice President of Acquisitions and Development
Denise W. Warren	52	Executive Vice President, Chief Financial Officer and Treasurer
Neil W. Kunkel	49	Executive Vice President, Chief Legal and Administrative Officer
Daniel S. Slipkovich	56	Executive Chairman of the Board and Co- Founder
J. Thomas Anderson	60	Vice-Chair, Co-Founder and Director
Joseph P. Nolan	49	Director
David S. Katz	48	Director
Robert Z. Hensley	56	Director

Michael A. Wiechart was named President and Chief Executive Officer in January 2014. Mr. Wiechart served as the Senior Vice President and Chief Operating Officer of Capella from May 2009 to January 2014. From February 2004 to May 2009, Mr. Wiechart served as a Group President and Division President of LifePoint. Prior to that, Mr. Wiechart served as a Division Chief Financial Officer of the LifePoint from May 1999 until February 2004. Prior to that time, Mr. Wiechart served as vice president/operations controller of Province Healthcare and in various financial positions with HCA. Mr. Wiechart earned a Bachelor of Science degree in Accounting from the University of Kentucky. Mr. Wiechart also earned a Lean Healthcare certification from the University of Tennessee at Knoxville.

D. Andrew Slusser was named Executive Vice President of Acquisitions and Development in January 2014. Mr. Slusser served as the Senior Vice President of Acquisitions and Development of Capella from the formation of Capella in April 2005 to January 2014. From April 1999 to April 2005, Mr. Slusser was the Vice President of Acquisitions and Development for Province Healthcare, responsible for all activities to develop and complete the acquisition of hospitals, including market identification, proposal presentation, negotiation of terms and conditions, pro forma financial statements and management of due diligence. Prior to that, Mr. Slusser was a founding officer and the Senior Vice President and Chief Financial Officer of Arcon Healthcare Inc., a provider of comprehensive ambulatory care services. He has also held Chief Financial Officer positions with HealthTrust and HCA, the latter including Western Group Chief Financial Officer with responsibility for 45 U.S. hospitals, five European hospitals and 125 surgical centers across the United States. Mr. Slusser is a certified public accountant (inactive). Mr. Slusser earned a Bachelor of Business Administration in Accounting from the University of Texas.

Denise W. Warren was named Executive Vice President, Chief Financial Officer, and Treasurer in January 2014. Ms. Warren served as the Senior Vice President, Chief Financial Officer and Treasurer of Capella from October 2005 and has more than 25 years of financial experience. In 2011 and 2012, Ms. Warren was named to Becker's Hospital Review as one of the top "Hospital and Health System CFOs To Know". Also in 2011, Ms. Warren was named by Nashville Medical News as a "Woman to Watch." In 2010, Ms. Warren was named as a "Woman of Influence in Tennessee" by the Nashville Business Journal. In 2009, Ms. Warren was named CFO of the Year for large private companies in Tennessee by the Nashville Business Journal. From 2001 to 2005, Ms. Warren served as a Senior Equity Analyst and former Research Director for Avondale Partners LLC ("Avondale"). Prior to her time at Avondale, from 2000 to 2001, Ms. Warren served as Senior Vice President and Chief Financial Officer for Gaylord Entertainment Company, a leading hospitality and entertainment organization ("Gaylord"). While at Gaylord, she was selected as Financial Executive of the Year by The Institute of Management Accountants. Prior to that, from 1996 to 2000, Ms. Warren worked in the New York office of Merrill Lynch & Co. as a Director and Senior Equity Analyst. Ms. Warren currently serves as a member of the Board of Governors of the Federation of American Hospitals, an investor-owned hospital industry group based in Washington, D.C. Ms. Warren earned a Bachelor of Science degree in Economics from

Southern Methodist University where she graduated Phi Beta Kappa, *summa cum laude*. Ms. Warren also earned a Master of Business Administration from Harvard University.

Neil W. Kunkel was named Executive Vice President, Chief Legal and Administrative Officer in January 2014. Mr. Kunkel served as the Senior Vice President, General Counsel and Secretary of Capella from October 2011. Before joining Capella, he was Vice-President and Associate General Counsel for LifePoint Hospitals, which he joined in 1998 prior to its spin-off from HCA in 1999. Prior to that time, Mr. Kunkel served first as Group Operations Counsel and then as Managing Counsel for HCA. A member of

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the Board of Governors of the Federation of American Hospitals, Neil has served as Chair and Vice-Chair of the Legal and Operations Policy Committee. He is currently serving as Chair of the Health Facilities Interest Group of the American Bar Association's Health Law Section. He is a member of the American Health Lawyers Association and a member of both the Tennessee and Kentucky Bar Associations. A graduate of Wake Forest University, Mr. Kunkel earned his law degree from the University of Louisville Law School, where he was a member of the Brandeis Honor Society.

Daniel S. Slipkovich became Executive Chairman of the Board in January 2014. Mr. Slipkovich has served as a director of Capella since May 2005 and served as the Chief Executive Officer from May 2005 to January 2014 and as President of Capella from August 2011. Mr. Slipkovich has managed hospitals in over 20 states through a career that has included investor relations, market strategies, physician recruitment and integration, clinical and operational management, joint venture structuring, information systems development, revenue cycle, HIPAA, ethics and compliance programs. From February 2004 until April 2005, Mr. Slipkovich served as the President and Chief Operating Officer of Province Healthcare, an operator of non-urban acute care hospitals, responsible for broad-based corporate activities as well as all hospital operations through three operating divisions with \$900 million in revenue. Prior to that, Mr. Slipkovich worked for HCA and spin-off companies, HealthTrust Purchasing Group ("HealthTrust") and LifePoint from 1983 to 2003. He previously served in hospital CFO positions and served in several Division Vice President positions and as Group Vice President for HCA in Florida responsible for hospital and ancillary operations with revenue of \$5 billion. He was promoted to Senior Vice President for HCA corporate, where he was responsible for the divestiture of 24 hospitals in the spin-off of LifePoint. In addition, Mr. Slipkovich serves on the board of directors of the Federation of American Hospitals and, in 2009, was named to Modern Healthcare's list of Top 100 Most Powerful People in Healthcare. Mr. Slipkovich is a certified public accountant. Mr. Slipkovich earned an Accounting degree from West Virginia University and attended graduate school at the University of Miami and Virginia Tech.

J. Thomas Anderson has been the Vice-Chair and Co-Founder of Capella since September 2010 and served as our President and a director from May 2005 to September 2010. From 1998 until 2005, Mr. Anderson served as the Senior Vice President of Acquisitions and Development for Province Healthcare during which time he developed growth strategies, managed the development of Province Healthcare's national market presence and closed transactions to acquire 18 hospitals representing \$900 million in annual net revenue. Prior to that, from 1992 to 1998, Mr. Anderson served as Vice President and Group Director for CHS, where he was responsible for the operations of 14 facilities in six states as well as new business development for CHS including the assimilation of 17 facilities when CHS acquired Hallmark Health Systems, Inc., a community-based nonprofit hospital operator in northern Boston. Mr. Anderson was previously the Chief Executive Officer and Chief Financial Officer of several community hospitals, including the Chief Financial Officer/Associate Administrator for Baptist Medical Center in Montgomery, Alabama and the Chief Executive Officer at Harton Regional Medical Center in Tullahoma, Tennessee. Mr. Anderson is a certified public accountant and began his career with HCA in accounting and internal audit. Mr. Anderson earned a Bachelor of Science degree in Accounting from Tennessee Technological University and a Master of Business Administration from Auburn University at Montgomery.

Joseph P. Nolan has been a director of Capella since May 2005. Mr. Nolan is the founder and Managing Director of Beverly Capital, a Chicago-based investment firm. Prior to founding Beverly, Mr. Nolan enjoyed a 20-year career as a Senior Principal and Senior Advisor with GTCR, a private equity firm currently managing in excess of \$7.3 billion. After joining GTCR in 1994, Mr. Nolan became a Senior Principal of the firm in 1996, a co-founder of GTCR Golder Rauner LLC in 1998, and led or co-led GTCR's healthcare investing efforts for much of his career, before becoming a Senior Advisor to the firm in 2012. Mr. Nolan has served as an investor and director of over 20 public and private companies including HealthSpring, Province healthcare, Managed Healthcare Associates, CompBenefits, Alliant Insurance Services and Devicor Medical Products. Mr. Nolan holds a MBA from the University of Chicago and a BS in Accounting with High Honors from the university of Illinois.

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David S. Katz has been a director of Capella since December 2006. Mr. Katz joined GTCR as a Principal in 2006 and is a Managing Director of the firm. Prior to joining GTCR, Mr. Katz served as a managing director of Frontenac Company, where he worked for 12 years. He also previously served as an associate of the Clipper Group and a consultant at the Boston Consulting Group. Mr. Katz also serves as a director of Curo Health Services Correctional Healthcare Corporation and Universal American and previously served as a director of Gevity HR and numerous other privately held companies. Mr. Katz graduated *cum laude* with a Bachelor of Arts in political science from Yale University and earned a Master's in Business Administration, where he graduated with distinction from Harvard University.

Robert Z. Hensley has been a director of Capella since January 2009. From July 2002 to September 2003, Mr. Hensley was an audit partner at Ernst & Young, LLP in Nashville, Tennessee. Prior to that, he served as an audit partner at Arthur Andersen LLP in Nashville, Tennessee from 1990 to 2002, and was managing partner of the Nashville, Tennessee office of Arthur Andersen LLP from 1997 to July 2002. Mr. Hensley is the founder and an owner of two real estate and rental property development companies, each of which is located in Destin, Florida. He also serves on the board of directors of Diversicare, a publically traded provider of long-term care services to nursing home patients and residents of assisted living facilities. He also currently serves on the board of several privately held companies. From 2011 to 2013, Mr. Hensley served on the board of directors of Greenway Medical Technologies, Inc., a publicly traded provider of software and services to ambulatory medical providers. From 2006 to 2010, Mr. Hensley also served as a director of COMSYS IT Partners, Inc., an information technology services company and Spheris, Inc., a provider of medical transcription technology and services. Since 2008, Mr. Hensley has served as a senior advisor to the healthcare and transaction advisory services groups of Alvarez and Marsal, LLC, a professional services company. Mr. Hensley holds a M.A. in Accountancy and a Bachelor of Science in Accounting from the University of Tennessee. Mr. Hensley is a certified public accountant.

Board of Directors and Board Committees

Capella's Board of Directors consists of five members, two of whom are designated by GTCR, one of whom is designated by a majority of our investors, one of whom is Capella's Executive Chairman of the Board (formerly Capella's President and Chief Executive Officer) and one of whom is the Vice-Chair and Co-Founder (who formerly was Capella's President and by agreement continues to serve on the Board of Directors). The Board of Directors currently has two standing committees: the Audit Committee and the Compensation Committee. Each of the directors designated by GTCR has the right to serve on all standing committees of the Board of Directors.

<u>Name of Director</u>	<u>Audit Committee</u>	<u>Compensation Committee</u>
J. Thomas Anderson	—	—
Robert Z. Hensley (1)	X	X
David S. Katz	X	X
Joseph P. Nolan	X	X
Daniel S. Slipkovich	—	—

- (1) Mr. Hensley is designated as the audit committee's financial expert. Capella is not subject to any listing standards but the Board believes that Mr. Hensley would be considered "independent" based on NYSE and NASDAQ listing standards.

Risk Oversight

We maintain a comprehensive, company-wide Ethics & Compliance program to address healthcare regulatory and other compliance requirements. This Ethics & Compliance program includes, among other things, initial and periodic ethics and compliance training, a toll-free reporting hotline for employees and annual coding audits. The organizational structure of our Ethics & Compliance program includes oversight by the Board of Directors and a high-level Corporate Ethics & Compliance Committee ("CECC"). The Vice President of Ethics & Compliance reports jointly to the Chief Executive Officer and to the Board of Directors, serves as the Chief Compliance Officer and is charged with direct responsibility for the day-to-day oversight of our compliance program.

Code of Ethics

We have a Code of Conduct which is applicable to all of our directors, officers and employees (the "Code of Conduct"). The Code of Conduct is available on the "Ethics and Compliance Program" page of our website at www.capellahealth.com.

Table of Contents**Item 11. Executive Compensation.****EXECUTIVE COMPENSATION****Summary Compensation Table**

The following table sets forth certain information concerning compensation paid or accrued by us and our subsidiaries for each of the last two years with respect to Capella's Chief Executive Officer and two other most highly compensated executive officers. (collectively, the "Named Executive Officers" or "NEOs"):

<u>Name and Principal Position</u>	<u>Year</u>	<u>Salary</u>	<u>Bonus (1)</u>	<u>Non-Equity Incentive Plan Compensation (2)</u>	<u>All Other Compensation (3)</u>	<u>Total</u>
Daniel S. Slipkovich	2013	\$650,000	\$112,427	\$ —	\$ 4,222	\$766,649
<i>President and Chief Executive Officer (4)</i>	2012	\$633,333	\$ —	\$ 300,000	\$ 4,562	\$937,895
Denise W. Warren	2013	\$450,007	\$ 91,767	\$ —	\$ 3,142	\$544,916
<i>Senior Vice President, Chief Financial Officer and Treasurer (5)</i>	2012	\$441,692	\$ —	\$ 200,000	\$ 3,482	\$645,174
Michael A. Wiechart	2013	\$450,007	\$ 92,020	\$ —	\$ 277,166	\$819,193
<i>Senior Vice President and Chief Operating Officer (6)</i>	2012	\$443,308	\$ —	\$ 200,000	\$ 277,506	\$920,814

- (1) The Compensation Committee and the Board of Directors may make discretionary bonuses outside of the non-equity incentive compensation plan. This flexibility is retained because the evaluation of the performance of an NEO may lead the Compensation Committee and the Board of Directors to determine that an NEO should receive additional compensation in a year regardless of whether the financial goal established under the non-equity incentive compensation plan is achieved. In 2013, Ms. Warren and Messrs. Slipkovich and Wiechart each received a discretionary bonus as outlined in the table above, some of which was in conjunction with the Company's management restructuring and reorganization plan.
- (2) Reflects cash awards earned under our non-equity incentive compensation plan. See the section below entitled "- Non-Equity Incentive Compensation Plan."
- (3) Details of the amounts included in "All Other Compensation" for 2013 are as follows:

	<u>Group term life</u>	<u>Long-term disability</u>	<u>Deferred Compensation (1)</u>	<u>Total</u>
Daniel S. Slipkovich	\$ 2,322	\$ 1,900	\$ —	\$ 4,222
Denise W. Warren	1,242	1,900	—	3,142
Michael A. Wiechart	810	1,900	274,456	277,166

- (1) Represents a reduction in liquidated damages as provided in Mr. Wiechart's employment agreement as a form of deferred compensation in connection with recruiting Mr. Wiechart to join Capella.

- (4) Daniel S. Slipkovich held the position of President and Chief Executive Officer through December 31, 2013.
- (5) Denise W. Warren was named Executive Vice President, Chief Financial Officer and Treasurer effective January 1, 2014.
- (6) Michael A. Wiechart was appointed to the role of President and Chief Executive Officer effective January 1, 2014.

Employment Agreements with the NEOs

Capella has entered into an employment agreement with each of the NEOs. Each of the employment agreements has substantially similar terms. The employment agreements establish the initial base salary of the applicable NEOs. The base salaries are reviewed and adjusted by the Compensation Committee of the Board of Directors once per year. In addition to the annual salary review, based upon the recommendations of the Chief Executive Officer, the Compensation Committee and the Board of Directors also may adjust base salaries at other times during the year in connection with promotions, increased responsibilities or to maintain competitiveness in the market. Additionally, the employment agreements establish the cash incentive bonus potential of each NEO under the non-equity compensation plan as a percentage of base salary. Mr. Slipkovich was eligible to earn a potential cash incentive bonus under the non-equity compensation plan of 100% of his base salary, and

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each of Ms. Warren and Mr. Wiechart was eligible to earn a potential cash incentive bonus under the non-equity compensation plan of 75% of his or her base salary.

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Under the terms of each employment agreement, the NEO and Capella may terminate the employment agreement at any time with or without cause. Under certain circumstances, an NEO may receive severance payments. See the section below entitled “- Potential Termination and Change-in-Control Payments.” Each NEO has agreed that during employment and for a certain period thereafter, such NEO may not directly or indirectly, anywhere in the United States, own, manage, control, participate in, consult with, render services for, or in any manner engage in any competing business with our businesses. Each of Mr. Slipkovich and Ms. Warren agreed that such restriction shall continue for a one year period after the end of his or her respective employment for any reason. Mr. Wiechart agreed that, if he voluntarily terminates his employment without good reason or is terminated for cause, he is subject to such restriction for two years following the end of his employment.

Potential Termination and Change-in-Control Payments

We believe that post-termination severance payments allow NEOs to receive value in the event of certain terminations of employment that were beyond their control. The protections afforded by post-termination severance payments allow management to focus its attention and energy on making the best objective business decisions that are in our interest without allowing personal considerations to cloud the decision-making process.

The employment agreements contain certain severance arrangements that provide for severance payments in the following circumstances:

- If Mr. Slipkovich is terminated without Cause or as a result of a Disability or death or he resigns for Good Reason, then he is entitled to receive his annual base salary for one year, and, upon termination without Cause or resignation for Good Reason, then he is also entitled to cause Holdings to purchase of portion of his shares of Holdings common stock at fair market value as of the date such right is exercised;
- If Ms. Warren is terminated without Cause or as a result of Disability or death, she is entitled to receive her annual base salary for one year; and
- If Mr. Wiechart is terminated without Cause or as a result of Disability or death or he resigns for Good Reason, he is entitled to receive his annual base salary for two years.

“Cause” is defined in each NEO’s employment agreement to mean (i) the commission of, or entry of a plea of guilty or nolo contendere, to a felony or a crime involving moral turpitude or any act or any other act or omission involving dishonesty or fraud with respect to Holdings, Capella or any of their respective subsidiaries or any of their customers or suppliers or stockholders, (ii) reporting to work repeatedly under the influence of alcohol or reporting to work under the influence of illegal drugs, the use of illegal drugs (whether or not at the workplace) or other repeated conduct causing Holdings, Capella or any of their respective subsidiaries substantial public disgrace or disrepute or substantial economic harm which, if curable, is not cured within 15 days following written notice thereof to the NEO, (iii) substantial and repeated failure to perform duties of the office held by the NEO as reasonably directed by the Board of Directors which is not cured within 15 days following written notice thereof to the NEO, (iv) a breach of the NEO’s duty of loyalty to Holdings, Capella or any of their respective subsidiaries or affiliates or any act of fraud or material dishonesty with respect to Holdings, Capella or any of their respective subsidiaries or (v) any material breach of the employment agreement or any other agreement between the NEO and Holdings, Capella or any of their respective affiliates which is not cured within 15 days after written notice thereof to the NEO.

“Disability” is defined in each NEO employment agreement to mean the disability of an NEO caused by any physical or mental injury, illness or incapacity as a result of which the NEO is unable to effectively perform the essential functions of the NEO’s duties as determined by the Board of Directors in good faith.

“Good Reason” is generally defined in each NEO’s employment agreement to mean (a) any decision by the Board of Directors which results in the primary business of Holdings being a business other than acquiring or operating acute-care hospitals, (b) substantial detrimental change in the positions or responsibilities of the NEO without the consent of the NEO, (c) where the NEO’s benefits under the employee benefit or health or welfare plan or programs of Holdings are in the aggregate materially decreased, excluding reductions because of benefit plan changes applicable to employees generally, (d) the failure by Holdings to pay the NEO’s base salary or to provide for the NEO’s annual bonus if and when due, (e) the relocation of the NEO’s primary place of employment to a location which is more than 100 miles from the city limits of Nashville, Tennessee; provided, however, that any of the foregoing (a) through (e) may be cured or remedied by Holdings within 30 days after

receiving notice thereof from the NEO.

The employment agreements do not provide any of the NEOs with cash severance upon a Sale of the Company, but any unvested common stock in Holdings acquired by an NEO in accordance with his or her employment agreement may become automatically vested, unless the Sale of the Company is a result of a Public Offering. A portion of common stock purchased by Mr. Slipkovich pursuant to his employment agreements remains unvested until immediately prior to a Sale of the Company or an initial Public Offering that would result in appreciation of the value of the unvested shares.

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“Public Offering” is defined in each NEO’s employment agreement to mean the sale in an underwritten public offering registered under the Securities Act of equity securities of Holdings or a corporate successor to Holdings.

“Sale of the Company” is defined in each NEO’s employment agreement to mean any transaction or series of transactions pursuant to which any person or group of related persons other than GTCR in the aggregate acquire(s) (i) equity securities of Holdings possessing the voting power (other than voting rights accruing only in the event of a default, breach or event of noncompliance) to

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elect a majority of the board of directors of Holdings (whether by merger, consolidation, reorganization, combination, sale or transfer of Holding's equity, stockholder or voting agreement, proxy, power of attorney or otherwise) or (ii) all or substantially all of Holding's assets determined on a consolidated basis; provided that a Public Offering shall not constitute a Sale of the Company.

The amount of estimated compensation payable to each NEO entitled to benefits if any such event had occurred on December 31, 2013 is listed in the tables below:

Daniel S. Slipkovich

<u>Executive Benefits and Payments upon Termination</u>	<u>Involuntary Termination without Cause</u>	<u>Resignation for Good Reason</u>	<u>Change in Control</u>	<u>Death or Disability</u>
Cash Payments	\$ 650,000	\$ 650,000	—	\$650,000
Accelerated Vesting of Unvested Restricted Stock	—	—	\$3,357,024(2)	—
Put Right	3,115,716(1)	3,115,716(1)	—	—

(1) Reflects the right to require Holdings to purchase (i) 299,171 shares of Holdings common stock based on a per share price of \$4.25 per share, which was determined to be the fair market value of Holdings common stock as of December 31, 2011 by a third-party appraiser. As a fair market value of Holdings has not been determined for the Company by a third party appraiser since December 31, 2011, the current fair market value of Holdings common stock could be materially different; and (ii) 1,841.94 shares of Holdings preferred stock at \$1,000 per share. In May 2005, Mr. Slipkovich originally purchased the shares of common stock for fair market value and 1,172.749 share of preferred stock for \$1,000 per share.

(2) Reflects the accelerated vesting of 789,888 shares of Holdings common stock that remain unvested until certain terms are met upon a Sale of the Company or an initial Public Offering. The amount of compensation reflected in this column is based on a per share price of \$4.25, which was determined to be the fair market value of Holdings common stock as of December 31, 2011 by a third-party appraiser. As a fair market value of Holdings has not been determined for the Company by a third-party appraiser since December 31, 2011, the current fair market value of Holdings common stock could be materially different. Mr. Slipkovich originally purchased these shares for fair market value in May 2005.

Denise W. Warren

<u>Executive Benefits and Payments upon Termination</u>	<u>Involuntary Termination without Cause</u>	<u>Resignation for Good Reason</u>	<u>Change in Control</u>	<u>Death or Disability</u>
Cash Payments	\$ 450,007	—	—	\$450,007
Accelerated Vesting of Unvested Restricted Stock	—	—	—	—

Michael A. Wiechart

<u>Executive Benefits and Payments upon Termination</u>	<u>Involuntary Termination without Cause</u>	<u>Resignation for Good Reason</u>	<u>Change in Control</u>	<u>Death or Disability</u>
Cash Payments	\$ 900,014	\$ 900,014	—	\$900,014
Accelerated Vesting of Unvested Restricted Stock	—	—	\$2,040,000(1)	—

(1) Reflects the accelerated vesting of 480,000 shares of Holdings common stock that remain unvested until certain terms are met upon a Sale of the Company, except in the case of an initial Public Offering. The amount of compensation reflected in this column is based on a per share price of \$4.25, which was determined to be the fair market value of Holdings common stock as of December 31, 2010 by an third-party appraiser. As a fair market value of Holdings has not been determined for the Company by a third-party appraiser completed since December 31, 2011, the current fair market value of Holdings common stock could be materially different. Mr. Wiechart originally purchased these shares for fair market value in May 2009.

Non-Equity Incentive Compensation Plan

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Certain of our corporate-level employees, including the NEOs, are eligible for a cash incentive bonus under our non-equity incentive compensation plan. When determining the amount of non-equity incentive compensation to be paid to each NEO, the Compensation Committee of the Board of Directors reviews and considers the following information:

- evaluations of each of the NEOs, as well as any feedback from the Board of Directors, regarding each NEO's performance;
- the Chief Executive Officer's review and evaluation of each of the other NEOs, addressing individual performance and the results of operations of the business areas and departments for which such executive had responsibility;

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- the financial performance of the Company, including achieving EBITDA goals established by the Chief Executive Officer and presented to and approved by the Board of Directors; and
- total proposed compensation, as well as each element of proposed compensation, taking into account the recommendations of the Chief Executive Officer.

Under the non-equity incentive compensation plan, cash incentive bonuses that are earned for achievement of pre-established performance goals are generally paid in the first four months of the year following the year during which such goals were achieved.

For 2013, the Compensation Committee of the Board of Directors, based on the recommendation of the Chief Executive Officer, determined a potential cash incentive bonus amount for each NEO based on a specific percentage of each NEO's base salary. For 2013, Mr. Slipkovich was eligible to earn a potential cash incentive bonus of 100% of his base salary, and each of Ms. Warren and Mr. Wiechart was eligible to earn a potential cash incentive bonus of 75% of his or her base salary (the "Maximum Cash Incentive Amount"). Each NEO can earn up to 100% of his or her Maximum Cash Incentive Amount if certain performance goals are achieved.

Equity Incentive Compensation

Equity incentive compensation awards historically have not been granted as an element of NEO compensation. The Board of Directors of Holdings has adopted the Capella Holdings, Inc. 2006 Stock Option Plan (the "2006 Stock Option Plan"), which permits the Board of Directors of Holdings to issue stock options to our directors, executive officers and other key personnel, subject to the terms and conditions set forth in the 2006 Stock Option Plan and in each option award. Holdings has never issued stock options under the 2006 Stock Option Plan. Additionally, although Holdings previously has granted restricted share awards to certain of our employees, no restricted share awards have been granted to the NEOs. The performance goals for 2013 were not achieved and, as a result, the NEOs did not receive cash incentive bonuses under the non-equity compensation plan.

DIRECTOR COMPENSATION

During the year ended December 31, 2013, none of our directors received compensation for their service as a member of the Board, except for Mr. Hensley as the only member of the Board that we believe would be considered "independent" based upon NYSE and NASDAQ listing standards. Mr. Anderson received other compensation from the Company pursuant to the agreement described below. All of our directors are reimbursed for reasonable expenses incurred in connection with their services.

<u>Name</u>	<u>Fees Earned or Paid in Cash</u>	<u>Stock Awards</u>	<u>All Other Compensation</u>	<u>Total</u>
J. Thomas Anderson	\$ —	\$ —	\$ 122,145(1)	\$122,145
Robert Z. Hensley	35,000	—	—	35,000

- (1) Mr. Anderson served as Capella's President from May 2005 to September 2010 and served as a director since 2005. In September 2010, Mr. Anderson's employment agreement was amended in connection with his transition from Capella's President to the position of Vice-Chair and Co-Founder. Mr. Anderson's employment agreement was further amended in August 2013, and his term will end on September 1, 2014 unless sooner terminated in accordance with his amended employment agreement. Pursuant to the employment agreement, Mr. Anderson received a salary of \$100,000 during 2013. Additionally, during the remaining term of his agreement, Mr. Anderson is eligible to earn an acquisition bonus of between 0% and 0.5% of the purchase or acquisition price of any transaction closed and consummated by Holdings, Capella or one of its subsidiaries. The amount of such bonus is subject to the discretion of the Board of Directors of Holdings, which will give consideration to factors such as input from the Chief Executive Officer and the amount of Mr. Anderson's involvement in the acquisition transaction. No such bonus was granted during 2013. Additionally, Mr. Anderson received group term life and long-term disability benefits totaling \$1,894 during 2013.

COMPENSATION COMMITTEE INTERLOCKS AND INSIDER PARTICIPATION

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Messrs. Hensley, Katz and Nolan served as members of our Compensation Committee throughout 2013. Although Messrs. Hensley, Katz and Nolan serve on the board of Holdings, none of them has at any time been an officer or employee of Capella, Holdings or any of their subsidiaries. Additionally, none of our executive officers has served as a member of another entity's compensation committee, one of whose executive officers served on our Compensation Committee or was one of our directors. Members of our Compensation Committee have certain relationships with Capella and Holdings, as described in the section below entitled "Item 13. Certain Relationships and Related Transactions, Director Independence."

Table of Contents**Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.**

All of Capella's capital stock is owned by our parent company, Holdings. The table below presents information with respect to the beneficial ownership of Holdings common stock and Holdings preferred stock as of December 31, 2013 by (a) any person or group who beneficially owns more than five percent of Holdings common stock or Holdings preferred stock, (b) each of Capella's directors and Named Executive Officers and (c) all directors and executive officers of Capella as a group. The percentages provided in the table are based on 63,172,160 shares of Holdings common stock and 340,504.594 shares of Holdings preferred stock outstanding as of January 31, 2014.

<u>Name of Beneficial Holder(1)</u>	<u>Shares of Common Stock Beneficially Owned(4)</u>	<u>Percentage of Common Stock Beneficially Owned</u>	<u>Shares of Preferred Stock Beneficially Owned(4)</u>	<u>Percentage of Preferred Stock Beneficially Owned</u>
GTCR(2)	50,000,000(5)	79.1%	340,616.619(7)	99.4%
Daniel S. Slipkovich (3)	4,880,521(6)	7.7	1,951.969	*
Denise W. Warren	799,247	1.3	—	—
Michael A. Wiechart	480,000	*	—	—
J. Thomas Anderson	3,771,511	6.0	—	—
Joseph P. Nolan	—	—	—	—
David S. Katz	—	—	—	—
Robert Z. Hensley	17,000	*	—	—
All directors and executive officers as a group (9 persons)	11,132,000	17.6	1,970.782	*

* Less than one percent.

- (1) Each owner has agreed to vote their shares in accordance with the Stockholders Agreement. See "Certain Relationships and Related Transactions — Stockholders Agreement."
- (2) The address of GTCR and Mr. Katz is 300 N. LaSalle Street, Suite 5600, Chicago, Illinois 60654. The address for of Mr. Nolan is Beverly Capital, LLC, 3201 Old Glenview Road #300, Willmette, Illinois 60091.
- (3) The address of Messrs. Slipkovich and Anderson is 501 Corporate Centre Drive, Franklin, Tennessee 37067.
- (4) Beneficial ownership includes voting or investment power with respect to securities and includes shares that an individual has a right to acquire within 60 days after January 31, 2014.
- (5) Includes 42,342,800, 7,431,200 and 226,000 shares owned by GTCR Fund VIII, L.P., GTCR Fund VIII/B, L.P. and GTCR Co-Invest II, L.P., respectively. Mr. Katz is a principal of GTCR and as such may be deemed to be a beneficial owner of these three funds. Mr. Katz disclaims beneficial ownership of such funds.
- (6) Includes 789,888 shares owned by Mr. Slipkovich with financial rights that do not vest until a sale of the Company or an initial public offering but for which Mr. Slipkovich currently has voting power.
- (7) Includes 288,453.224, 50,623.807 and 1,539.589 shares owned by GTCR Fund VIII, L.P., GTCR Fund VIII/B, L.P. and GTCR Co-Invest II, L.P., respectively.

Item 13. Certain Relationships and Related Transactions, and Director Independence.**Certain Relationships and Related Transactions**

In accordance with its written charter, the Audit Committee reviews and approves all material related party transactions. Prior to its approval of any material related party transaction, the Audit Committee will discuss the proposed transaction with management and our independent auditor. In addition, our Code of Conduct requires that all of our employees, including our executive officers, remain free of conflicts of interest in the performance of their responsibilities to the Company. An executive officer who wishes to enter into a transaction in which his or her interests may conflict with ours must first receive the approval of the Audit Committee.

Stock Purchase Agreement

In accordance with a Stock Purchase Agreement, dated May 4, 2005, as amended by Supplement No. 1 to the Stock Purchase Agreement, dated April, 2007 and Amendment and Supplement No. 2 to the Stock Purchase Agreement, dated

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February 29, 2008 (collectively, the "Purchase Agreement"), Holdings authorized the issuance and sale to GTCR of 196,000,000 shares of Holdings Cumulative Redeemable Preferred Stock and 50,000,000 shares of Holdings common stock. At the initial closing, GTCR purchased 25,000,000 shares of Holdings common stock at a price of \$0.08 per share for gross proceeds of \$2,000,000. At such time, GTCR intended to provide up to \$198,000,000 in equity financing to Holdings as the equity portion of the debt and equity financing necessary to fund the acquisition of acute care hospitals, in each case as approved by the board of directors of Holdings and by GTCR. Such additional equity financing would be provided through the purchase by GTCR of up to 25,000,000 shares of Holdings common stock at \$0.08 per share and 196,000,000 shares of Holdings preferred stock at \$1,000 per share (each such purchase, a "Subsequent

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Closing"). As of December 31, 2013, 50,000,000 shares of Holdings common stock and 205,541,741 shares of Holdings preferred stock have been purchased by GTCR in Subsequent Closings. This agreement called for the execution of employment agreements with executive management (see "Executive Compensation-Summary Compensation Table-Employment Agreements"), a Stockholders Agreement, a Registration Rights Agreement and a Professional Services Agreement. Pursuant to the Purchase Agreement, Holdings may not, among other things, without the prior written consent of the majority holders, pay any dividends or make distributions, make or permit any subsidiaries, including Capella, to make any loans or advances, or merge or consolidate with any person. Under the Purchase Agreement, Holdings agreed to pay certain expenses of GTCR, including fees and expenses incurred with respect to any amendments or waivers and stamp and other taxes in connection with the Purchase Agreement.

Stockholders Agreement

The Stockholders Agreement includes various provisions such as restrictions with respect to the designation of the board of directors of Holdings, sale of the stock, tag-along rights and rights of first refusal. Certain of the transfer restrictions expired on May 4, 2010. The tag-along rights allow all stockholders to participate in any potential sale of Holdings stock by GTCR. The right of first refusal gives Holdings a right of first refusal on the same terms as a proposed transfer until the earliest of a public offering, the time of a public sale by a stockholder, the consummation of an approved sale, or the date on which such stock has been transferred under the right of first refusal. If the board of directors of Holdings and the holders of a majority of the Holdings common stock held by GTCR and its affiliates (the "Investor Majority") approve a sale of Holdings, each holder of shares shall vote for the sale. If the sale is a (i) merger or consolidation, each holder waives all dissenter's rights and appraisal rights, (ii) a sale of stock, each holder of shares shall agree to sell all of his shares or rights to acquire shares on the terms and conditions approved by the Holdings Board and the Investor Majority or (iii) sale of assets, each holder of shares shall vote such holder's shares to approve such sale.

Registration Rights Agreement

In connection with the Purchase Agreement with GTCR, we entered into the Registration Rights Agreement, dated May 4, 2005. At any time, GTCR may request registration under the Securities Act of all or any portion of its registrable securities of Holdings. GTCR may request an unlimited number of both short-form and long-form registrations. Holdings must give prompt written notice of its intent to register any securities in order to allow for piggy-back registration rights of the holders of registrable securities. Whenever the holders of registrable securities have requested that any registrable securities be registered pursuant to the Registration Rights Agreement, Holdings must use its best efforts to effect the registration and the sale of such registrable securities in accordance with the intended method of disposition.

Professional Services Agreement

In connection with the Purchase Agreement, Capella and GTCR Golder Rauner II, L.L.C. entered into a Professional Services Agreement, dated May 4, 2005, as amended by that Amendment No. 1 to Professional Services Agreement, dated November 30, 2005, in order to provide financial and management consulting services to the Company. GTCR Golder Rauner II, L.L.C. agreed to consult on matters including, but not limited to, corporate strategy, budgeting of future corporate investments, acquisition and divestiture strategies and debt and equity financings in exchange for an annual fee of \$100,000, which has been subsequently increased to \$150,000 per the terms of the Professional Service Agreement. The Professional Services Agreement also provides that at the time of any debt financing prior to our initial public offering, Capella shall pay to GTCR Golder Rauner II, L.L.C. a placement fee in an amount mutually determined between us and GTCR Golder Rauner II, L.L.C., or its affiliate, provided that such placement fee shall not exceed one percent of the gross amount of such debt financing. The agreement will continue until GTCR and its affiliates no longer own at least 10% of the Holdings common stock and Holdings preferred stock issued under the Purchase Agreement. The Professional Services Agreement also calls for GTCR to be reimbursed by Capella for certain out of pocket expenses incurred in connection with the rendering of various services under this agreement.

Director Independence

Though not formally considered by the Board of Directors because our common stock is not currently listed or traded on any national securities exchange, based upon the listing standards of the New York Stock Exchange ("NYSE") and NASDAQ, we do not believe that any of our directors other than Mr. Hensley would be considered "independent" because of their

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relationships with us or GTCR, which holds significant interests in Holdings, which owns 100% of our outstanding stock. Accordingly, we do not believe that Messrs. Katz or Nolan, members of our Audit Committee and Compensation Committee, would meet the independence requirements of Rule 10A-1 of the Exchange Act, or the NYSE's independence requirements. We do not have a nominating/corporate governance committee, or a committee that serves a similar purpose.

Table of Contents**Item 14. Principal Accountant Fees and Services.**

The table below provides information concerning fees for services rendered by Ernst & Young LLP during the last two fiscal years. The nature of the services provided in each such category is described following the table.

<u>Description of Fees</u>	<u>Amount of Fees</u>	
	<u>2012</u>	<u>2013</u>
Audit Fees	\$ 965,426	\$1,122,866
Audit-Related Fees	407,021	
Tax Fees	87,541	52,708
Total	<u>\$1,459,988</u>	<u>\$1,175,574</u>

Audit Fees — These fees were primarily for professional services rendered by Ernst & Young LLP in connection with the audit of the Company's consolidated annual financial statements, reviews of the interim condensed consolidated financial statements and its quarterly report on Form 10-Q for the first three fiscal quarters of the fiscal years ended December 31, 2012 and 2013.

Audit-Related Fees — These fees were primarily for services rendered by Ernst & Young LLP for transactional related services.

Tax Fees — These fees were for services rendered by Ernst & Young LLP for assistance with tax compliance regarding tax filings and also for other tax advice and consulting services.

Pre-approval of Services Performed by the Independent Registered Public Accounting Firm

The charter of the Audit Committee provides that the Audit Committee must pre-approve all services to be provided by the independent auditors prior to the commencement of work. Unless the specific service has been pre-approved with respect to that year, the Audit Committee must approve the permitted service before the independent auditors are engaged to perform it. For 2013, all services provided by Ernst & Young LLP were pre-approved by the Audit Committee.

The Audit Committee considered and determined that the provision of non-audit services by Ernst & Young LLP during 2012 and 2013 was compatible with maintaining auditor independence. None of these services is of a type that is prohibited under the independent registered public accounting firm independence standards of the SEC.

Table of Contents**PART IV****Item 15. Exhibits, Financial Statement Schedules.****(a) Index to Consolidated Financial Statements, Financial Statement Schedules and Exhibits:****(1) Consolidated Financial Statements:**

See Item 8 in this report.

The consolidated financial statements required to be included in Part II, Item 8, *Financial Statements and Supplementary Data*, begin on Page F- 1 and are submitted as a separate section of this report.

(2) Consolidated Financial Statement Schedules:

All schedules are omitted because they are not applicable or not required, or because the required information is included in the consolidated financial statements or notes in this report.

(b) Exhibits:

<u>Exhibit Number</u>	<u>Description</u>
3.1	Certificate of Incorporation of Capella Healthcare, Inc. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
3.2	By-Laws of Capella Healthcare, Inc. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
4.1	Indenture, dated as of June 28, 2010, among Capella Healthcare, Inc., the Guarantors named therein and U.S. Bank National Association, as Trustee (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
4.2	Form of 9 1/4% Senior Notes due 2017 (included in Exhibit 4.1) (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
4.3	Form of Supplemental Indenture to add a Guaranty Subsidiary (incorporated by reference from exhibits to the Quarterly Report on Form 10-Q filed by Capella Healthcare, Inc. on November 2, 2012)
4.4	Registration Rights Agreement, dated as of June 28, 2010, among Capella Healthcare, Inc., the Guarantors party thereto, and Banc of America Securities LLC, as representatives of the initial purchasers named therein (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.1	Stock Purchase Agreement, dated as of May 4, 2005, by and among Capella Holdings, Inc., GTCR Fund VIII, L.P., GTCR Fund VIII/B, L.P., GTCR Co-Invest II, L.P. and the other investors named therein (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.2	Supplement No. 1 to the Stock Purchase Agreement, dated as of April, 2007, by and among Capella Holdings, Inc., GTCR Fund VIII, L.P., GTCR Fund VIII/B, L.P., GTCR Co-Invest II, L.P. and the other investors named therein (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.3	Amendment and Supplement No. 2 to the Stock Purchase Agreement, dated as of February 29, 2008, by and among Capella Holdings, Inc., GTCR Fund VIII, L.P., GTCR Fund VIII/B, L.P., GTCR Co-Invest II, L.P. and the other investors named therein (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.4	Stockholders Agreement, dated as of May 4, 2005, by and among Capella Holdings, Inc., GTCR Fund VIII, L.P., GTCR Fund VIII/B, L.P., GTCR Co-Invest II, L.P. and the other investors named therein (incorporated by reference

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from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)

- 10.5 Amendment No. 1 to the Stockholders Agreement, dated as of February 29, 2008, by and among Capella Holdings, Inc., GTCR Fund VIII, L.P., GTCR Fund VIII/B, L.P., GTCR Co-Invest II, L.P. and the other investors named therein (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
- 10.6 Registration Rights Agreement, dated as of May 4, 2005, by and among Capella Holdings, Inc., GTCR Fund VIII, L.P., GTCR Fund VIII/B, L.P., GTCR Co-Invest II, L.P. and the other investors named therein (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)

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<u>Exhibit Number</u>	<u>Description</u>
10.7	Professional Services Agreement, dated as of May 4, 2005, between GTCR Golder Rauner II, LLC and Capella Healthcare, Inc. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.8	Amendment No. 1 to Professional Services Agreement between GTCR Golder Rauner II, LLC and Capella Healthcare, Inc., dated as of November 30, 2005 (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.9	Loan and Security Agreement, dated June 28, 2010, by and among Capella Healthcare, Inc. and certain borrowing subsidiaries as Borrowers, certain guarantying subsidiaries as Guarantors, certain financial institutions as Lenders, Bank of America, N.A. as Agent and Collateral Agent, Citibank, N.A. as Syndication Agent, Barclays Bank PLC and General Electric Capital Corporation as Co-Documentation Agents and Bank of America Securities LLC and Citigroup Global Markets Inc. as Co-Lead Arrangers and Co-Book Managers (incorporated by reference from exhibits to the Registration Statement on Form S-4/A filed by Capella Healthcare, Inc. on September 23, 2011, File No. 333-175188) **
10.10	Form of Joinder to Loan and Security Agreement (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.11	Consent Agreement and Amendment No. 1 to Loan Agreement, dated January 27, 2012, by and among Capella Healthcare, Inc. and certain borrowing subsidiaries as Borrowers, certain guarantying subsidiaries as Subsidiary Guarantors, certain financial institutions as Lenders, and Bank of America, N.A. as Agent (incorporated by reference from exhibits to the Quarterly Report on Form 10-Q filed by Capella Healthcare, Inc. on August 3, 2012)
10.12	Consent Agreement and Amendment No. 2 to Loan Agreement, dated June 29, 2012, by and among Capella Healthcare, Inc. and certain borrowing subsidiaries as Borrowers, certain guarantying subsidiaries as Subsidiary Guarantors, certain financial institutions as Lenders, and Bank of America, N.A. as Agent (incorporated by reference from exhibits to the Quarterly Report on Form 10-Q filed by Capella Healthcare, Inc. on August 3, 2012)
10.13	Senior Management Agreement, dated as of May 4, 2005, by and among Capella Holdings, Inc., Capella Healthcare, Inc. and Daniel S. Slipkovich (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.14	Amendment No. 1 to Senior Management Agreement, dated as of May 12, 2006, by and among Capella Holdings, Inc., Capella Healthcare, Inc., Daniel S. Slipkovich and GTCR Fund VIII, L.P. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.15	Senior Management Agreement, dated as of May 4, 2005, by and among Capella Holdings, Inc., Capella Healthcare, Inc. and James Thomas Anderson (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.16	Amendment No. 1 to Senior Management Agreement, dated as of May 12, 2006, by and among Capella Holdings, Inc., Capella Healthcare, Inc., James Thomas Anderson and GTCR Fund VIII, L.P. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.17	Amendment No. 2 to Senior Management Agreement, dated as of September 1, 2010, by and among Capella Holdings, Inc., Capella Healthcare, Inc., James Thomas Anderson and GTCR Fund VIII, L.P. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.18	Amendment No. 3 to Senior Management Agreement, dated August 31, 2013, by and among Capella Holdings, Inc., Capella Healthcare, Inc. and James Thomas Anderson (incorporated by reference from exhibits to the Quarterly

Report on Form 10-Q filed by Capella Healthcare, Inc., on November 8, 2013, File No. 333-175188)*

- 10.19 Senior Management Agreement, dated May 4, 2005, by and among Capella Holdings, Inc., Capella Healthcare, Inc. and David Andrew Slusser (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
- 10.20 Amendment No. 1 to Senior Management Agreement, dated as of May 12, 2006, by and among Capella Holdings, Inc., Capella Healthcare, Inc., David Andrew Slusser and GTCR Fund VIII, L.P. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *

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<u>Exhibit Number</u>	<u>Description</u>
10.21	Senior Management Agreement, dated as of October 17, 2005, by and among Capella Holdings, Inc., Capella Healthcare, Inc. and Denise Wilder Warren (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.22	Amendment No. 1 to Senior Management Agreement, dated as of May 12, 2006, by and among Capella Holdings, Inc., Capella Healthcare, Inc., Denise Wilder Warren and GTCR Fund VIII, L.P. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.23	Senior Management Agreement, dated as of May 26, 2009, by and among Capella Holdings, Inc., Capella Healthcare, Inc. and Michael Wiechart (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.24	Form of Amendment No. 1 to Senior Management Agreement, dated as of August 24, 2011, by and among Capella Holdings, Inc., Capella Healthcare, Inc., Michael Wiechart and GTCR Fund VIII, L.P. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.25	Capella Holdings, Inc. 2006 Stock Option Plan (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.26	Capella Holdings, Inc. Deferred Compensation Plan (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.27	Computer and Data Processing Services Agreement, effective February 21, 2011, by and among HCA-Information Technology & Services, Inc. and Capella Healthcare, Inc. (incorporated by reference from exhibits to the Registration Statement on Form S-4/A filed by Capella Healthcare, Inc. on September 23, 2011, File No. 333-175188) **
10.28	Amendment No. 001 to Computer and Data Processing Services Agreement, effective May 5, 2011, by and among HCA-Information Technology & Services, Inc. and Capella Healthcare, Inc. (incorporated by reference from exhibits to the Registration Statement on Form S-4/A filed by Capella Healthcare, Inc. on September 23, 2011, File No. 333-175188) **
10.29	Lease Agreement, dated April 3, 2007, by and among Muskogee Medical Center Authority, d/b/a Muskogee Regional Medical Center, Muskogee Regional Medical Center, LLC, and Capella Healthcare, Inc. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.30	Form of Redemption Agreement (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.31	Senior Management Agreement, dated September 20, 2011, by and among Capella Holdings, Inc., Capella Healthcare, Inc. and Neil W. Kunkel (incorporated by reference from exhibits to the Quarterly Report on Form 10-Q filed by Capella Healthcare, Inc. on November 11, 2011) *
21	Subsidiaries of Registrant
31.1	Certification of the Chief Executive Officer of Capella Healthcare, Inc. pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of the Chief Financial Officer of Capella Healthcare, Inc. pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of the Chief Executive Officer of Capella Healthcare, Inc. pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

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Certification of the Chief Financial Officer of Capella Healthcare, Inc. pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

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<u>Exhibit Number</u>	<u>Description</u>
101.INS	XBRL Instance Document***
101.SCH	XBRL Taxonomy Extension Schema Document***
101.CAL	XBRL Taxonomy Calculation Linkbase Document***
101.DEF	XBRL Taxonomy Definition Linkbase Document***
101.LAB	XBRL Taxonomy Label Linkbase Document***
101.PRE	XBRL Taxonomy Presentation Linkbase Document***

* Management compensatory plan or arrangement.

** Certain information has been omitted pursuant to a confidential treatment request filed with the SEC.

*** Furnished electronically herewith

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<u>Report of Independent Registered Public Accounting Firm</u>	F-2
<u>Consolidated Balance Sheets as of December 31, 2012 and 2013</u>	F-3
<u>Consolidated Statements of Operations for the years ended December 31, 2011, 2012 and 2013</u>	F-4
<u>Consolidated Statements of Stockholder's Deficit for the years ended December 31, 2011, 2012 and 2013</u>	F-5
<u>Consolidated Statements of Cash Flows for the years ended December 31, 2011, 2012 and 2013</u>	F-6
<u>Notes to Consolidated Financial Statements</u>	F-7

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Table of Contents**Report of Independent Registered Public Accounting Firm**

The Board of Directors and Stockholder
Capella Healthcare, Inc.

We have audited the accompanying consolidated balance sheets of Capella Healthcare, Inc., a wholly owned subsidiary of Capella Holdings, Inc., as of December 31, 2013 and 2012, and the related consolidated statements of operations, stockholder's deficit, and cash flows for each of the three years in the period ended December 31, 2013. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Capella Healthcare, Inc. at December 31, 2013 and 2012, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2013, in conformity with U.S. generally accepted accounting principles.

/s/ Ernst & Young LLP

Nashville, Tennessee
March 11, 2014

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Capella Healthcare, Inc.
Consolidated Balance Sheets
(In millions, except for share and per share amounts)

	December 31, <u>2012</u>	<u>2013</u>
Assets		
Current assets:		
Cash and cash equivalents	\$ 33.3	\$ 26.4
Accounts receivable, net of allowance for doubtful accounts of \$93.6 and \$105.5 at December 31, 2012 and 2013, respectively	123.5	126.3
Inventories	24.8	24.3
Prepaid expenses and other current assets	4.9	5.0
Other receivables	6.6	6.6
Assets held for sale	—	13.1
Deferred tax assets	1.7	2.5
Total current assets	194.8	204.2
Property and equipment:		
Land	37.9	37.8
Buildings and improvements	399.4	389.4
Equipment	215.5	245.1
Construction in progress (estimated cost to complete and equip at December 31, 2013 is \$6.5 million)	15.6	8.0
	668.4	680.3
Accumulated depreciation	(194.8)	(224.2)
	473.6	456.1
Goodwill	136.0	133.6
Intangible assets, net	10.7	13.2
Other assets, net	29.3	23.7
Total assets	<u>\$ 844.4</u>	<u>\$ 830.8</u>
Liabilities and stockholder's deficit		
Current liabilities:		
Accounts payable	\$ 31.1	\$ 28.5
Salaries and benefits payable	23.1	23.8
Accrued interest	23.3	23.3
Other accrued liabilities	20.9	32.7
Current portion of long-term debt	8.4	49.6
Liabilities held for sale	—	1.9
Total current liabilities	106.8	159.8
Long-term debt	543.4	507.8
Deferred income taxes	14.1	17.3
Other liabilities	30.3	28.4
Redeemable non-controlling interests	21.1	21.4
Due to parent	210.5	210.9
Stockholder's deficit:		
Common stock, \$0.01 par value; 1,000 shares authorized; 100 shares issued and outstanding at December 31, 2012 and 2013, respectively	—	—
Retained deficit	(81.8)	(114.8)
Total stockholder's deficit	(81.8)	(114.8)
Total liabilities and stockholder's deficit	<u>\$ 844.4</u>	<u>\$ 830.8</u>

See accompanying notes.

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Capella Healthcare, Inc.
Consolidated Statements of Operations
(In millions)

	Year Ended December 31,		
	2011	2012	2013
Revenue before provision for bad debts	\$723.7	\$802.3	\$ 828.5
Provision for bad debts	(72.3)	(84.1)	(106.2)
Revenue	651.4	718.2	722.3
Costs and expenses:			
Salaries and benefits	313.9	333.2	342.8
Supplies	108.3	114.8	123.1
Other operating expenses	144.7	177.7	185.5
Other income	(7.2)	(6.4)	(12.6)
Management fee to related party	0.2	0.2	0.2
Interest, net	51.1	53.1	55.0
Depreciation and amortization	31.8	37.8	44.2
Total costs and expenses	642.8	710.4	738.2
Income (loss) from continuing operations before income taxes	8.6	7.8	(15.9)
Income taxes	1.4	3.0	4.0
Income (loss) from continuing operations	7.2	4.8	(19.9)
Loss from discontinued operations, net of tax	(20.5)	(17.6)	(11.4)
Net loss	(13.3)	(12.8)	(31.3)
Less: Net income attributable to non-controlling interests	1.2	1.3	0.5
Net loss attributable to Capella Healthcare, Inc.	<u>\$ (14.5)</u>	<u>\$ (14.1)</u>	<u>\$ (31.8)</u>

See accompanying notes.

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Capella Healthcare, Inc.
Consolidated Statements of Stockholder's Deficit
(In millions, except for share amounts)

	<u>Common Stock</u>		<u>Retained Deficit</u>	<u>Total Stockholder's Deficit</u>
	<u>Shares</u>	<u>Amount</u>		
Balance at January 1, 2011	100	\$ —	\$ (48.0)	\$ (48.0)
Adjustment to redemption value of redeemable non-controlling interests	—	—	(1.1)	(1.1)
Net loss	—	—	(14.5)	(14.5)
Balance at December 31, 2011	100	—	(63.6)	(63.6)
Adjustment to redemption value of redeemable non-controlling interests	—	—	(0.6)	(0.6)
Establishment of non-controlling interests related to St. Thomas joint venture	—	—	(3.5)	(3.5)
Net loss	—	—	(14.1)	(14.1)
Balance at December 31, 2012	100	—	(81.8)	(81.8)
Adjustment to redemption value of redeemable non-controlling interests	—	—	(1.2)	(1.2)
Net loss	—	—	(31.8)	(31.8)
Balance at December 31, 2013	100	\$ —	<u>\$(114.8)</u>	<u>\$ (114.8)</u>

See accompanying notes.

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Capella Healthcare, Inc.
Consolidated Statements of Cash Flows

	Year Ended December 31,		
	2011	2012	2013
	(In Millions)		
Operating activities			
Net loss	\$(13.3)	\$(12.8)	\$ (31.3)
Adjustments to reconcile net loss to net cash provided by operating activities:			
Loss from discontinued operations	20.5	17.6	11.4
Depreciation and amortization	31.8	37.8	44.2
Amortization of loan costs and debt discount	2.8	3.9	4.0
Provision for bad debts	72.3	84.1	106.2
Deferred income taxes	1.2	2.0	3.1
Stock-based compensation	0.8	1.0	0.8
Changes in operating assets and liabilities, net of effect of acquisitions:			
Accounts receivable, net	(72.9)	(97.2)	(113.6)
Inventories	(2.6)	(0.3)	(0.6)
Prepaid expenses and other current assets	(6.0)	0.3	(0.3)
Accounts payable and other current liabilities	6.5	7.1	11.2
Accrued salaries	(1.0)	1.2	0.7
Accrued interest	(0.4)	—	—
Other	(0.7)	1.8	(2.1)
Net cash provided by operating activities – continuing operations	39.0	46.5	33.7
Net cash provided by (used in) operating activities – discontinued operations	4.0	(2.5)	(2.9)
Net cash provided by operating activities	43.0	44.0	30.8
Investing activities			
Purchases of property and equipment, net	(31.3)	(32.9)	(26.3)
Acquisition of healthcare businesses	(34.1)	(26.0)	—
Proceeds from disposition of healthcare businesses	20.5	12.4	1.6
Change in other assets	(1.8)	—	—
Net cash used in investing activities – continuing operations	(46.7)	(46.5)	(24.7)
Net cash used in investing activities – discontinued operations	(2.9)	(0.9)	(2.1)
Net cash used in investing activities	(49.6)	(47.4)	(26.8)
Financing activities			
Payments on capital leases and other obligations	—	(2.7)	(9.8)
Advances (to) from Parent	3.8	(0.4)	0.3
Payment of debt issue costs	—	(0.2)	—
Distributions to non-controlling interests	(1.0)	(1.7)	(1.2)
Repurchase of non-controlling interests	(0.3)	(1.1)	(0.2)
Net cash provided by (used in) financing activities – continuing operations	2.5	(6.1)	(10.9)
Net cash (used in) provided by financing activities – discontinued operations	(1.8)	0.4	—
Net cash provided by (used in) financing activities	0.7	(5.7)	(10.9)
Change in cash and cash equivalents	(5.9)	(9.1)	(6.9)
Cash and cash equivalents at beginning of year	48.3	42.4	33.3
Cash and cash equivalents at end of year	<u>\$ 42.4</u>	<u>\$ 33.3</u>	<u>\$ 26.4</u>
Supplemental disclosure of cash flow information			
Cash paid for interest	<u>\$ 47.2</u>	<u>\$ 47.1</u>	<u>\$ 51.2</u>
Cash paid for taxes	<u>\$ 0.5</u>	<u>\$ 0.4</u>	<u>\$ 1.6</u>
Supplemental schedule of non-cash investing and financing activities:			

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Capital lease obligations

\$ —

\$ 50.3

\$ 14.5

See accompanying notes.

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements
December 31, 2013

1. Organization and Significant Accounting Policies**Organization**

Capella Healthcare, Inc., a Delaware corporation which was formed on April 15, 2005, is a wholly owned subsidiary of Capella Holdings, Inc. (the "Parent"). The Company operates hospitals and ancillary healthcare facilities in non-urban communities in the United States. Unless the context otherwise indicates, Capella Healthcare, Inc. is referred to herein as "Capella" or the "Company".

At December 31, 2013, as part of continuing operations, the Company operated eleven general acute care hospitals and ancillary healthcare facilities with a total of 1,504 licensed beds. Unless noted otherwise, discussions in these notes pertain to the Company's continuing operations, which exclude the results of those facilities that have been previously disposed.

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and all subsidiaries and entities controlled by the Company through the Company's direct or indirect ownership of a majority interest and exclusive rights granted to the Company as the sole general partner of such entities. All intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of the accompanying consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Discontinued Operations

In accordance with the provisions of the Financial Accounting Standards Board ("FASB") authoritative guidance regarding accounting for the impairment or disposal of long-lived assets, the Company has presented the operating results, financial position and cash flows of its previously disposed facilities as discontinued operations, net of income taxes, in the accompanying consolidated financial statements.

General and Administrative Costs

The majority of the Company's expenses are "cost of revenue" items. Costs that could be classified as "general and administrative" by the Company would include its corporate overhead costs, which were \$14.1 million, \$25.5 million and \$23.7 million for the years ended December 31, 2011, 2012 and 2013, respectively.

Fair Value of Financial Instruments

The carrying amounts reported in the consolidated balance sheets for cash and cash equivalents, accounts receivable and accounts payable approximate fair value because of the short-term nature of these instruments. The carrying amount of the Company's 9 1/4% Senior Unsecured Notes due 2017 (the "9 1/4% Notes") was \$500.0 million at December 31, 2013 as disclosed in Note 5. The estimated fair value of the 9 1/4% Notes at December 31, 2013 was approximately \$532.5 million and based on the average bid and ask price as quoted by the Company's administrative agent and is categorized as Level 2 within the fair value hierarchy in accordance with Accounting Standards Codification ("ASC") 820-10, "Fair Value Measurements and Disclosures".

Revenue Recognition and Accounts Receivable

The Company recognizes revenue before the provision for bad debts, including revenue from in-house patients and patients which have been discharged but not yet billed, in the period in which services are performed. Accounts receivable

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primarily consist of amounts due from third-party payors and patients. The Company's ability to collect outstanding receivables is critical to its results of operations and cash flows. The Company has entered into agreements with third-party payors, including government programs and managed care health plans, under which the Company is paid based upon established charges, the cost of providing services, predetermined rates per diagnosis, fixed per diem rates or discounts from established charges. Amounts the Company receives for treatment of patients covered by governmental programs such as Medicare and Medicaid and other third-party payors such as health maintenance organizations, preferred provider organizations and other private insurers are generally less than the Company's established billing rates. Accordingly, the revenues and accounts receivable reported in the Company's consolidated financial statements are recorded at the amount expected to be received.

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

The year ended December 31, 2012 included an additional \$7.0 million of revenue related to the State of Oklahoma's Supplemental Hospital Offset Payment Program, or SHOPP, in which the Company's Oklahoma hospitals participate. SHOPP allows for the establishment of a hospital provider fee assessment on all non-exempt Oklahoma hospitals. Revenue from this assessment is used to maintain hospital reimbursement from the SoonerCare Medicaid program and to secure additional matching Medicaid funds from the federal government. On January 17, 2012, the Centers for Medicare & Medicaid Services ("CMS") approved SHOPP with an effective date of July 1, 2011. Based on the approval date of January 17, 2012, the Company recorded the \$7.0 million of additional revenue related to SHOPP from the period of July 1, 2011 through December 31, 2011 during the year ended December 31, 2012.

The year ended December 31, 2012 included \$6.6 million of revenue related to the industry-wide rural floor provision settlement litigation. The Balanced Budget Act of 1997, or BBA, established a rural floor provision, by which an urban hospital's wage index within a particular state could not be lower than the statewide rural wage index. The wage index reflects the relative hospital wage level compared to the applicable average hospital wage level. The BBA also made this provision budget neutral, meaning that total wage index payments nationwide before and after the implementation of this provision must remain the same. To accomplish this, CMS was required to increase the wage index for all affected urban hospitals and to calculate a rural floor budget neutrality adjustment to reduce other wage indexes in order to maintain the same level of payments. Litigation had been pending for several years contending that CMS miscalculated the neutrality adjustment from 1999 through 2011. The litigation was settled effective April 5, 2012.

The following table sets forth the percentages of revenue before the provision for bad debts by payor for the years ended December 31, 2011, 2012 and 2013:

	Year Ended December 31,		
	2011	2012(2)	2013
Medicare(1)	39.2%	39.2%	38.1%
Medicaid(1)	12.8	15.3	14.4
Managed Care and other	37.9	35.3	36.0
Self-Pay	10.1	10.2	11.5
Total	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>

- (1) Includes revenue before the provision for bad debts received under managed Medicare or managed Medicaid programs.
- (2) The increase in Medicaid revenue for fiscal 2012 is due primarily to SHOPP. SHOPP increased Medicaid revenue for fiscal 2012 by approximately \$21.5 million.

The Company derives a significant portion of its revenue before the provision for bad debts from Medicare, Medicaid and other payors that receive discounts from the Company's standard charges. The Company must estimate the total amount of these discounts to prepare its consolidated financial statements. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex and are subject to interpretation and adjustment. The Company estimates the allowance for contractual discounts on a payor-specific basis given its interpretation of the applicable regulations or contract terms. These interpretations sometimes result in payments that differ from the Company's estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management. Changes in estimates related to the allowance for contractual discounts affect revenues reported in the Company's consolidated statements of operations.

Settlements under reimbursement agreements with third-party payors are estimated and recorded in the period the related services are rendered and are adjusted in future periods as final settlements are determined. Final determination of amounts earned under the Medicare and Medicaid programs often occurs subsequent to the year in which services are rendered because of audits by

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

the programs, rights of appeal and the application of numerous technical provisions. There is at least a reasonable possibility that such estimates will change by a material amount in the near term. The net estimated third-party payor settlements payable by the Company as of December 31, 2012 totaled \$4.5 million compared to \$5.7 million as of December 31, 2013. The net estimated third-party payor settlements are included in other current liabilities in the accompanying consolidated balance sheets. The net adjustments to estimated cost report settlements resulted in a decrease to revenue of \$0.2 million for the year ended December 31, 2011, an increase of \$1.1 million for the year ended December 31, 2012, and an increase of \$0.3 million for the year ended December 31, 2013. The Company's management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these programs.

Laws and regulations governing Medicare and Medicaid programs are complex and subject to interpretation. The Company believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on the Company's financial statements. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

Provision for Bad Debts and Allowance for Doubtful Accounts

To provide for accounts receivable that could become uncollectible in the future, the Company establishes an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value.

Additions to the allowance for doubtful accounts are made by means of the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance for doubtful accounts and subsequent recoveries are added. The amount of the provision for bad debts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal, state, and private employer healthcare coverage and other collection indicators. The provision for bad debts and the allowance for doubtful accounts relate primarily to "uninsured" amounts (including copayment and deductible amounts from patients who have healthcare coverage) due directly from patients. Accounts are written off when all reasonable internal and external collection efforts have been performed. The Company considers the return of an account from the primary external collection agency to be the culmination of its reasonable collection efforts and the timing basis for writing off the account balance. Accounts written off are based upon specific identification and the write-off process requires a write-off adjustment entry to the patient accounting system. Management relies on the results of detailed reviews of historical write-offs and recoveries (the hindsight analysis) as a primary source of information to utilize in estimating the collectibility of the Company's accounts receivable. The Company performs the hindsight analysis on a quarterly basis for all hospitals, utilizing rolling twelve-month accounts receivable collection, write-off, and recovery data. The Company supplements its hindsight analysis with other analytical tools, including, but not limited to, revenue days in accounts receivable, historical cash collections experience and revenue trends by payor classification. Adverse changes in general economic conditions, billing and collections operations, payor mix, or trends in federal or state governmental healthcare coverage could affect the Company's collection of accounts receivable, cash flows and results of operations.

A summary of activity in the Company's allowance for doubtful accounts is as follows (in millions):

	Balances at Beginning of Year	Additions Charged to provision for bad debts	Accounts Written Off, Net of Recoveries	Balances at End of Year
Year ended December 31, 2011	\$ 123.1	\$ 72.3	\$ (108.8)	\$ 86.6
Year ended December 31, 2012	\$ 86.6	\$ 84.1	\$ (77.1)	\$ 93.6
Year ended December 31, 2013	\$ 93.6	\$ 106.2	\$ (94.3)	\$ 105.5

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Charity Care

Self-pay revenue is derived primarily from patients who do not have any form of healthcare coverage. The Company provides care without charge to certain patients that qualify under the Company's charity/indigent care policy. The Company does not report a charity/indigent care patient's charges in revenues or in the provision for bad debts as it is the Company's policy not to pursue collection of amounts related to these patients. At the Company's hospitals, patients treated for non-elective care, who have income at or below 200% of the federal poverty level, are eligible for charity care. The federal poverty level is established by the federal government and is based on income and family size. The Company's hospitals provide a discount to uninsured patients who do not qualify for Medicaid or charity care. These discounts are similar to those provided to many local managed care plans. In implementing the discount policy, the Company first attempts to qualify uninsured patients for Medicaid, other federal or state assistance or charity care. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

The Company estimates its cost of care provided under its charity care programs utilizing a calculated ratio of costs to gross charges multiplied by the Company's gross charity care charges provided. For the years ended December 31, 2011, 2012 and 2013, the Company estimates that its costs of care provided under its charity care programs were approximately \$2.9 million, \$3.4 million and \$2.8 million, respectively.

Concentration of Revenues

For the years ended December 31, 2011, 2012 and 2013, approximately 52.0%, 54.5% and 52.5%, respectively, of the Company's revenue before the provision for bad debts related to patients participating in the Medicare and Medicaid programs. The Company's management recognizes that revenue and receivables from government agencies are significant to the Company's operations, but it does not believe that there are significant credit risks associated with these government agencies. The Company's management does not believe that there are any other significant concentrations of revenue from any particular payor that would subject the Company to any significant credit risks in the collection of its accounts receivable.

Other Income

The American Recovery and Reinvestment Act of 2009 ("ARRA") provides for incentive payments under the Medicare and Medicaid programs for certain hospitals and physician practices that demonstrate meaningful use of certified electronic health record ("EHR") technology. These provisions of ARRA, collectively referred to as the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), are intended to promote the adoption and meaningful use of interoperable health information technology and qualified EHR technology.

The Company accounts for EHR incentive payments in accordance with ASC 450-30, "Gain Contingencies" ("ASC 450-30"). In accordance with ASC 450-30, the Company recognizes a gain for EHR incentive payments when its eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. The demonstration of meaningful use is based on meeting a series of objectives and varies among hospitals and physician practices, between the Medicare and Medicaid programs and within the Medicaid program from state to state. Additionally, meeting the series of objectives in order to demonstrate meaningful use becomes progressively more stringent as its implementation is phased in through stages as outlined by the CMS.

For the years ended December 31, 2011, 2012 and 2013, the Company recognized \$7.2 million, \$6.4 million and \$12.6 million, respectively, in EHR incentive payments in accordance with the HITECH Act under the Medicaid and Medicare programs which is included in other income on the accompanying consolidated statements of operations. Amounts recognized as other income that the Company anticipates collecting in future periods, but that were uncollected as of the balance sheet date are included in the accompanying consolidated balance sheet. As of December 31, 2012 and 2013, outstanding receivables from Medicaid for EHR incentive payments totaled approximately \$1.4 million and \$2.0 million, respectively and is included in other receivables on the accompanying consolidated balance sheets.

The Company incurs both capital expenditures and operating expenses in connection with the implementation of its various EHR initiatives. The amount and timing of these expenditures does not necessarily directly correlate with the timing of the Company's receipt or recognition of the EHR incentive payments.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash on hand and marketable securities with original maturities of three months or less. The Company places its cash in financial institutions that are federally insured in limited amounts.

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Inventories

Inventories are stated at the lower of cost (first-in, first-out) or market and are principally composed of medical supplies and pharmaceuticals. These inventory items are primarily operating supplies used in the direct or indirect treatment of patients.

Long-Lived Assets*Property and Equipment*

Property and equipment are stated at cost less accumulated depreciation. Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase capacities or extend useful lives are capitalized. Fully depreciated assets are retained in property and equipment accounts until they are disposed.

Depreciation is computed by applying the straight-line method over the estimated useful lives of buildings and improvements and equipment. Assets under capital leases are amortized using the straight-line method over the shorter of the estimated useful life of the assets or the lease term, excluding any lease renewals, unless the lease renewals are reasonably assured. Buildings and improvements are depreciated over estimated lives ranging generally from ten to forty years. Estimated useful lives of equipment vary generally from three to ten years. Depreciation and amortization expense totaled approximately \$31.8 million, \$37.8 million and \$44.2 million for the years ended December 31, 2011, 2012 and 2013, respectively. Amortization expense related to assets under the Company's capital leases is included under depreciation and amortization expense for the years ended December 31, 2012 and 2013.

At December 31, 2012 and 2013, assets under the Company's capital leases are as follows (in millions):

	<u>2012</u>	<u>2013</u>
Buildings and improvements	\$37.0	\$ 37.0
Equipment	15.5	29.8
Total	52.5	66.8
Accumulated amortization	(3.8)	(12.8)
Total, net	<u>\$48.7</u>	<u>\$ 54.0</u>

The Company evaluates its long-lived assets for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future cash flows. Fair value estimates are derived from established market values of comparable assets or internal calculations of estimated future net cash flows.

The Company's estimates of future cash flows are based on assumptions and projections it believes to be reasonable and supportable. The Company's assumptions take into account revenue and expense growth rates, patient volumes, changes in payor mix, changes in legislation and other payor payment patterns.

Deferred Loan Costs

The Company records deferred loan costs for expenditures related to acquiring or issuing new debt instruments. These expenditures include bank fees and premiums, as well as attorneys' and filing fees. Deferred loan costs totaled approximately \$11.4 million and \$8.3 million, net of accumulated amortization of approximately \$10.2 million and \$13.3 million at December 31, 2012 and 2013, respectively, and are included in other assets on the accompanying consolidated balance sheets. The Company amortizes these deferred loan costs to interest expense over the life of the respective debt instrument, using the effective interest method.

Goodwill and Intangible Assets

The Company accounts for its acquisitions under the provisions of FASB authoritative guidance regarding business combinations and goodwill and other intangible assets. Goodwill represents the excess of the cost of an acquired entity over

the net of the amounts assigned to assets acquired and liabilities assumed. Goodwill and intangible assets with indefinite lives are reviewed by the Company at least annually for impairment. The Company's business comprises a single reporting unit for impairment test purposes. For the purposes of these analyses, the Company's estimates of fair value are based on the income approach, which estimates the fair value of the Company based on its future discounted cash flows. In addition to the annual impairment reviews, impairment reviews are performed whenever circumstances indicate a possible impairment may exist. The Company performed its annual impairment tests as of October 1, and did not incur any impairment charges, other than with respect to discontinued operations, during the years ended December 31, 2011, 2012 and 2013.

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

The Company's intangible assets relate to contract-based physician minimum revenue guarantees, a non-competition agreement and certificates of need. The contract-based physician revenue guarantees are amortized over the terms of the respective agreements. The certificates of need were determined to have indefinite lives and, accordingly, are not amortized.

Physician Minimum Revenue Guarantees

The Company has committed to provide certain financial assistance pursuant to recruiting agreements, or "physician minimum revenue guarantees," with various physicians practicing in the communities it services. In consideration for a physician relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician, to assist in establishing his or her practice.

The Company accounts for its physician minimum revenue guarantees in accordance with the provisions of FASB authoritative guidance regarding accounting for minimum revenue guarantees. The Company records a contract-based intangible asset and related guarantee liability for new physician minimum revenue guarantees. The contract-based intangible asset is amortized to other operating expenses over the period of the respective physician contract, which is typically four years.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date. The Company assesses the likelihood that deferred tax assets will be recovered from future taxable income. To the extent the Company believes that recovery is more likely than not, a valuation allowance is established. To the extent the Company establishes a valuation allowance or increases this allowance, the Company must include an expense within the provision for income taxes in the consolidated statements of operations.

The Company follows the provisions of FASB authoritative guidance regarding income taxes. This guidance clarifies the accounting for uncertainties in income taxes recognized in financial statements and requires the impact of a tax position to be recognized in the financial statements if that position is more likely than not of being sustained by the taxing authority.

Other Accrued Liabilities

The Company's other accrued liabilities, shown as a current liability in the accompanying audited consolidated balance sheet, consist of the following:

	Year Ended December 31,	
	2012	2013
	(In millions)	
Employee health IBNR reserve	\$ 3.2	\$ 3.4
Professional and general liability claims	2.7	2.5
Non-income tax accrual	2.1	2.6
Physician income guarantees liability	0.7	2.8
Workers' compensation liability claims	0.9	1.1
Income taxes payable	0.6	0.1
Estimated amounts due to third party payors	4.5	5.7
Deferred revenue related to EHR	—	7.3
Other	6.2	7.2
Total	<u>\$20.9</u>	<u>\$32.7</u>

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Professional and General Liability Claims

Given the nature of the Company's operating environment, the Company is subject to potential medical malpractice lawsuits and other claims as part of providing healthcare services. To mitigate a portion of this risk, the Company maintains insurance through Auriga Insurance Group, a wholly owned subsidiary of the Parent ("Auriga"), for professional and general claims of \$4.75 million per occurrence and \$14.25 million in the aggregate per policy year, subject to a \$0.25 million self-insured retention per occurrence. The Company also maintains umbrella policies for professional and general claims which cover an additional \$60 million per occurrence and in the aggregate. The Company's reserves for professional and general liability claims are based upon independent actuarial calculations, which consider historical claims data, demographic considerations, severity factors, and other actuarial assumptions in determining reserve estimates. Reserve estimates are discounted to present value using a 1% discount rate.

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Exposures at the Company's hospitals prior to the date of their respective acquisition are indemnified by the respective prior owners. Accordingly, the Company appropriately has not estimated any exposure for claims prior to the respective acquisition dates of its facilities. The Company utilized certain information to estimate its 2012 and 2013 liability for professional and general liability claims. Using historical claim payments and developments, the Company estimated the exposure for each of its facilities and recorded a reserve of approximately \$29.7 million (\$12.0 million of which is due from Auriga) and \$26.7 million (\$12.6 million of which is due from Auriga) at December 31, 2012 and 2013, respectively. The reserves due from Auriga are included in other liabilities on the accompanying consolidated balance sheets.

The current portion of the reserves was \$2.7 million and \$2.5 million at December 31, 2012 and 2013, respectively and is included in other accrued liabilities on the accompanying consolidated balance sheets. The long-term portion of the reserves for professional and general liability claims is included in other liabilities on the accompanying consolidated balance sheets.

The Company's expense for professional and general liability claims each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; amortization of the insurance premiums for losses in excess of the Company's self-insured retention level; the administrative costs of the insurance program; and interest expense related to the discounted portion of the liability. The total expense recorded under the Company's professional and general liability insurance program for the years ended December 31, 2011, 2012 and 2013, was approximately \$5.6 million, \$6.3 million and \$7.5 million, respectively.

Workers' Compensation Reserves

Given the nature of the Company's operating environment, it is subject to potential workers' compensation claims as part of providing healthcare services. To mitigate a portion of this risk, the Company maintained insurance for individual workers' compensation claims exceeding approximately \$250,000 per occurrence. The Company's facility located in the state of Washington participates in a state-specific program rather than the Company's established program. The Company's two facilities located in Oklahoma participate in a fully insured state-specific workers' compensation program.

The Company's reserve for workers' compensation is based upon an independent third-party actuarial calculation, which considers historical claims data, demographic considerations, development patterns, severity factors and other actuarial assumptions. Reserve estimates are undiscounted and are revised on an annual basis. The reserve for workers' compensation claims at the balance sheet date reflects the current estimate of all outstanding losses, including incurred but not reported losses, based upon an actuarial calculation. The Company's reserve for workers' compensation claims was approximately \$3.4 million and \$3.7 million at December 31, 2012 and 2013, respectively. The current portion of the reserves, \$0.9 million and \$1.1 million at December 31, 2012 and 2013, respectively, is included in other accrued liabilities on the accompanying consolidated balance sheets. The long-term portion of the reserves for workers' compensation claims is included in other liabilities on the accompanying consolidated balance sheets.

The Company's expense for workers' compensation claims each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; amortization of the insurance premiums for losses in excess of the Company's self-insured retention level; and the administrative costs of the insurance program. The total expense recorded under the Company's workers' compensation insurance program for the years ended December 31, 2011, 2012 and 2013, was approximately \$2.2 million, \$1.8 million and \$1.9 million, respectively.

Self-Insured Medical Benefits

The Company is self-insured for substantially all of the medical expenses and benefits of its employees. The reserve for medical benefits primarily reflects the current estimate of incurred but not reported losses, based upon an actuarial calculation. The undiscounted reserve for self-insured medical benefits was approximately \$3.2 million and \$3.4 million at December 31, 2012 and 2013, respectively, and is included in other accrued liabilities on the accompanying consolidated balance sheets. The

Company purchases stop loss coverage from Auriga Insurance Group, in which the Company will be reimbursed for any employee's medical claims that exceed \$0.35 million per year.

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Redeemable Non-controlling Interests

The Company's accompanying consolidated financial statements include all assets, liabilities, revenue and expenses of less than 100% owned entities controlled by the Company. Accordingly, management has recorded non-controlling interests in the earnings and equity of such consolidated entities.

The Company's non-controlling interests include redemption features, including the ability to redeem interest upon death and retirement, which cause these interests not to meet the requirements for classification as permanent equity in accordance with FASB authoritative guidance. Redemption of these non-controlling interest features would require the delivery of cash. Accordingly, these non-controlling interests are classified in the mezzanine section of the Company's accompanying consolidated balance sheets. A rollforward of the redeemable non-controlling interests is shown in the table below:

	<u>Redeemable Non-controlling Interests</u> <u>(in millions)</u>
Balance at December 31, 2011	\$ 18.0
Net income attributable to non-controlling interests	1.3
Distributions to non-controlling interests	(1.7)
Repurchase of non-controlling interests	(1.1)
Adjustment to redemption value of redeemable non-controlling interests	0.6
Establishment of non-controlling interests related to St. Thomas joint venture	4.0
Balance at December 31, 2012	21.1
Net income attributable to non-controlling interests	0.5
Distributions to non-controlling interests	(1.2)
Repurchase of non-controlling interests	(0.2)
Adjustment to redemption value of redeemable non-controlling interests	1.2
Balance at December 31, 2013	<u>\$ 21.4</u>

Effective April 30, 2012, the Company entered into a joint venture agreement with St. Thomas Health ("St. Thomas") in Tennessee. In exchange for a 6.49% minority ownership at four of the Company's hospitals, St. Thomas contributed approximately \$0.5 million in equipment. St. Thomas will also co-brand these Tennessee hospitals as well as clinically support certain services and future growth opportunities. The fair value of the St. Thomas non-controlling interest at December 31, 2013 was approximately \$4.0 million and is included in redeemable non-controlling interests on the accompanying consolidated balance sheet.

Segment Reporting

The Company owns and operates eleven hospitals as part of continuing operations as of December 31, 2013. The Company manages its hospitals as one operating segment, healthcare services, for segment reporting purposes in accordance with ASC 280-10, "Segment Reporting".

Reclassifications

Certain prior year amounts have been reclassified to conform to the current year presentation.

Stock-Based Compensation

The board of directors of the Parent has adopted the Capella Holdings, Inc. 2006 Stock Option Plan (the "2006 Stock Option Plan"), which permits the board of directors of the Parent to issue stock options and other stock-based awards to certain of the Company's employees, subject to the terms and conditions set forth in the 2006 Stock Option Plan and in each award. The Parent has never issued stock options under the 2006 Stock Option Plan. The Parent has granted restricted share awards that typically vest over a five year period to certain of the Company's employees. The Company accounts for its stock-based awards in accordance with the

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

provisions of ASC 718-10 "Compensation – Stock Compensation", ("ASC 718-10"). In accordance with ASC 718-10, the Company recognized compensation expense based on the estimated grant date fair value of each stock-based award of \$0.8 million, \$1.0 million, and \$0.8 million for the years ended December 31, 2011, 2012, and 2013, respectively. The stock-based compensation expense is included in salaries and benefits in the accompanying consolidated statements of operations.

2. Business Combinations**2012 Business Combinations***Acquisition of Muskogee RT Associates, LLC*

Effective March 16, 2012, the Company acquired the assets of Muskogee RT Associates, LLC d/b/a Artesian Cancer Center at Muskogee ("MRTA") in Muskogee, Oklahoma. The cash purchase price was \$6.5 million and was funded with cash on hand. The Company has finalized its application of the acquisition method of accounting based upon its estimates of fair value of assets acquired and liabilities assumed at the acquisition date, which resulted in goodwill of \$6.5 million.

Lease of Muskogee Community Hospital

Effective July 1, 2012, the Company executed an asset purchase agreement in which the Company acquired specific property and components of net working capital, as defined, and certain intangible assets for \$21.4 million. Of the purchase price, \$8.4 million is in the form of a promissory note payable ("MCH Note") in fifteen equal monthly installments beginning in July 2013. The MCH Note is included in current and long-term debt on the accompanying consolidated balance sheet as of December 31, 2012.

The Company also executed a master lease agreement for the real property and certain equipment used in the operation of MCH. Under the master lease agreement, the Company pays a lease payment of \$565,000 per month, which payment will be adjusted for inflation beginning in the third year of the lease. The Company has the option to purchase the leased real property and equipment at fair value as defined in the master lease agreement on July 20, 2014. If the Company does not exercise this initial purchase option, it has the option to exercise the purchase upon the expiration of the initial lease term (15 years). The Company also has an option to renew the lease for an additional 15 years, after which the Company could also exercise a purchase option for fair value. The Company has recorded the master lease agreement as a capital lease and is included in current debt on the accompanying consolidated balance sheet as of December 31, 2013.

The acquisition of certain property and equipment and the net assets pursuant to the MCH asset purchase agreement was funded with cash on hand and through the execution of the MCH Note. The Company has finalized its application of the acquisition method of accounting.

The fair values of assets acquired and liabilities assumed at the acquisition date are as follows (in millions):

Accounts receivable, net	\$ 2.7
Prepays and other	0.2
Inventories	0.7
Property and equipment	3.0
Non-competition agreement	4.5
Goodwill	14.3
Total assets acquired	<u>25.4</u>
Accounts payable	3.3
Salaries and benefits payable	0.7
Total liabilities assumed	<u>4.0</u>
Net assets acquired	<u>\$21.4</u>

Acquisition-related expenses for MCH were \$1.1 million for the year ended December 31, 2012 and are included in other operating expenses on the accompanying consolidated statements of operations.

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Acquisition of Southwest Imaging Center, Inc and Raindancer LLC d/b/a Doctors MRI

Effective December 31, 2012 the Company acquired the assets of Southwest Imaging Center, Inc. and Raindancer LLC d/b/a Doctors MRI ("the Imaging Centers") in Lawton, Oklahoma. The cash purchase price for the Imaging Centers was \$6.5 million and was funded with cash on hand. The Company completed its application of the acquisition method of accounting based upon its estimates of fair value of assets acquired and liabilities assumed at the acquisition date.

The fair values of assets acquired at the acquisition date are as follows (in millions):

Property and equipment	\$1.3
Goodwill	<u>5.2</u>
Total assets acquired	<u>\$6.5</u>

Acquisition-related expenses for the Imaging Centers were \$0.1 million for the year ended December 31, 2012 and are included in other operating expenses on the accompanying consolidated statements of operations.

3. Discontinued Operations

On December 28, 2011, the Company sold the assets and operations of Parkway Medical Center ("Parkway"), a 120-bed facility located in Decatur, Alabama. The proceeds from the sale were \$20.5 million. The Company retained certain working capital of Parkway. The loss recorded on the sale of Parkway totaled approximately \$6.7 million in 2011.

On March 15, 2012, the Company completed the sale of Hartselle Medical Center ("Hartselle"), a 150-bed facility located in Hartselle, Alabama for \$1.6 million. The Company retained all working capital of Hartselle, with the exception of inventory. The loss on the sale of Hartselle totaled \$5.3 million in 2011.

On December 31, 2012, the Company completed the sale of Jacksonville Medical Center ("Jacksonville"), an 89-bed facility located in Jacksonville, Alabama for \$6.0 million plus \$3.0 million for working capital. The loss recorded on the sale of Jacksonville totaled approximately \$6.7 million in 2012.

On September 1, 2013, the Company completed the sale of certain home health operations at our Arkansas facilities. The combined proceeds from the sale were approximately \$1.6 million. The recorded gain totaled approximately \$1.2 million.

On February 28, 2014, the Company completed the sale of Grandview Medical Center ("Grandview"), a 70-bed facility located in Jasper, Tennessee. In connection with the planned divestiture, the Company recognized an estimated loss on the sale totaling \$7.0 million during the year ended December 31, 2013. The Company has presented the operating results, financial positions and cash flows as discontinued operations in the accompanying consolidated financial statements for all periods, and the related assets and liabilities are reflected as held for sale in the accompanying consolidated balance sheet at December 31, 2013.

The Company has estimated the fair value of its assets and liabilities held for sale at December 31, 2013 at approximately \$13.1 million and \$1.9 million, respectively. The estimated fair value is based on the amount outlined in the executed purchase agreement and is categorized as Level 3 within the fair value hierarchy in accordance with ASC 820-10, "Fair Value Measurements and Disclosures".

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Revenue before the provision for bad debts and the loss reported in discontinued operations are as follows (in millions):

	Year Ended December 31,		
	2011	2012	2013
Revenue before the provision for bad debts from discontinued operations	<u>\$126.5</u>	<u>\$66.3</u>	<u>\$31.1</u>
Loss from discontinued operations			
Loss (gain) from sale from discontinued operations, net	12.0	8.1	(1.2)
Loss from held for sale adjustment	—	—	7.0
Loss from impairment of goodwill	4.2	1.0	1.8
Loss from operations	<u>4.3</u>	<u>8.5</u>	<u>4.5</u>
Pre-tax loss from discontinued operations	20.5	17.6	12.1
Tax benefit related to discontinued operations	—	—	(0.7)
Loss from discontinued operations, net of tax	<u>\$ 20.5</u>	<u>\$17.6</u>	<u>\$11.4</u>

The following table provides the components of assets and liabilities held for sale related to Grandview (in millions):

	December 31, 2013
Accounts receivable, net	\$ 4.3
Inventories	1.0
Prepaid expenses and other current assets	0.3
Property and equipment, net	<u>7.5</u>
Assets held for sale	<u>\$ 13.1</u>
Accounts payable	\$ 1.2
Salaries and benefits payable	<u>0.7</u>
Liabilities held for sale	<u>\$ 1.9</u>

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

4. Goodwill and Intangible Assets

The following table presents a roll-forward of the Company's goodwill for the year ended December 31, 2013 (in millions):

	<u>Goodwill</u>
Balance at January 1, 2013	\$ 136.0
Adjustment to goodwill related to prior acquisitions	(0.6)
Impairment of goodwill related to the planned disposal of Grandview Medical Center	(1.8)
Balance at December 31, 2013	<u>\$ 133.6</u>

The following table presents the components of the Company's intangible assets at December 31, 2012 and 2013 (in millions):

<u>Class of Intangible Assets</u>	<u>Gross Carrying Amount</u>	<u>Accumulated Amortization</u>	<u>Net Total</u>
Amortized intangible assets:			
Contract-based physician minimum revenue guarantees:			
2012	\$ 12.4	\$ (6.7)	\$ 5.7
2013	\$ 13.8	\$ (5.3)	\$ 8.5
Non-competition agreements:			
2012	\$ 4.5	\$ (0.2)	\$ 4.3
2013	\$ 4.5	\$ (0.5)	\$ 4.0
Indefinite-lived intangible assets:			
Certificates of need			
2012	\$ 0.7	\$ —	\$ 0.7
2013	\$ 0.7	\$ —	\$ 0.7
Total intangible assets:			
2012	\$ 17.6	\$ (6.9)	\$10.7
2013	\$ 19.0	\$ (5.8)	\$13.2

Contract-Based Physician Minimum Revenue Guarantees

As discussed in Note 1, the Company records a contract-based intangible asset and a related guarantee liability for each new physician minimum revenue guarantee contract. The contract-based intangible asset is amortized into other operating expense over the period of the physician contract, which is typically four years. The Company has committed to advance a maximum amount of approximately \$4.5 million at December 31, 2013. As of December 31, 2012 and 2013, the Company's liability balance for contract-based physician minimum revenue guarantees was approximately \$0.7 million and \$2.8 million, respectively, which is included in other accrued liabilities in the accompanying consolidated balance sheets.

Non-Competition Agreements

The Company has entered into non-competition agreements with certain physicians and other individuals as part of the acquisition of MCH. These non-competition agreements are amortized on a straight-line basis over the fifteen year term of the agreements.

Certificates of Need

The construction of new facilities, the acquisition or expansion of existing facilities and the addition of new services and certain equipment at the Company's facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificates of need laws generally require that a state agency determine the public need and give approval

prior to the construction or acquisition of facilities of the addition of new services. The Company operates hospitals in certain states that have adopted certificate of need laws. If the Company fails to obtain necessary state approval, the Company will not be able to expand its facilities, complete acquisitions or add new services at its facilities in these states. An independent appraiser values each certificate of need when the Company acquires a hospital. In addition, these intangible assets were determined to have indefinite lives and, accordingly, are not amortized.

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Amortization Expense

Total estimated amortization expense for the Company's intangible assets during the next five years and thereafter are as follows (in millions):

2014	\$ 4.1
2015	2.6
2016	1.8
2017	1.0
2018	0.3
Thereafter	2.7
	<u>\$12.5</u>

5. Debt Obligations

The following table presents a summary of the Company's debt obligations at December 31, 2012 and 2013 (in millions):

	December 31, 2012	December 31, 2013
9 1/4% Notes	\$ 500.0	\$ 500.0
Unamortized discount on 9 1/4% Notes	(4.1)	(3.2)
Total 9 1/4% Notes	\$ 495.9	\$ 496.8
Capital lease obligations	47.5	55.5
MCH promissory note	8.4	5.1
Total debt obligations	\$ 551.8	\$ 557.4
Less current maturities	8.4	49.6
Total	<u>\$ 543.4</u>	<u>\$ 507.8</u>

Maturities of the Company's long-term debt at December 31, 2013 are as follows (in thousands):

2014	\$ 49.6
2015	3.5
2016	3.6
2017	503.9
2018	—
Thereafter	—
	<u>\$560.6</u>

9 1/4% Senior Unsecured Notes

In June 2010, the Company completed a comprehensive refinancing plan (the "Refinancing"). Under the Refinancing, the Company issued \$500 million of new 9 1/4% Senior Unsecured Notes due 2017 (the "9 1/4% Notes") and entered into a new senior secured asset-based loan ("ABL"), consisting of a \$100 million revolving credit facility maturing in December 2014 (the "2010 Revolving Facility"). The proceeds from the 9 1/4% Notes were used to repay the outstanding principal and interest related to the Company's 2008 bank credit agreement and to pay fees and expenses relating to the Refinancing of approximately \$21.7 million.

Interest on the 9 1/4% Notes is payable semi-annually on July 1 and January 1 of each year. The 9 1/4% Notes are unsecured general obligations of the Company and rank equal in right of payment to all existing and future senior unsecured indebtedness of the Company. All payments on the 9 1/4% Notes are guaranteed jointly and severally on a senior unsecured

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basis by the Company and its subsidiaries, other than those subsidiaries that do not guarantee the obligations of the borrowers under the Company's prior senior credit facilities.

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

The Company may redeem up to 35% of the 9 1/4% Notes prior to July 1, 2013, with the net cash proceeds from certain equity offerings at a price equal to 109.25% of their principal amount, plus accrued and unpaid interest. The Company may redeem all or a part of the 9 1/4% Notes at any time on or after July 1, 2013, plus accrued and unpaid interest, if any, to the date of redemption plus a redemption price equal to a percentage of the principal amount of the notes redeemed based on the following redemption schedule:

July 1, 2013 to June 30, 2014	106.938%
July 1, 2014 to June 30, 2015	104.625%
July 1, 2015 to June 30, 2016	102.313%
July 1, 2016 and thereafter	100.000%

If the Company experiences a change of control under certain circumstances, the Company must offer to repurchase all of the notes at a price equal to 101.000% of their principal amount, plus accrued and unpaid interest, if any, to the repurchase date.

The 9 1/4% Notes contain customary affirmative and negative covenants, which among other things, limit the Company's ability to incur additional debt, create liens, pay dividends, effect transactions with its affiliates, sell assets, pay subordinated debt, merge, consolidate, enter into acquisitions and effect sale leaseback transactions.

Upon the occurrence of certain events, the Company may request the 2010 Revolving Facility to be increased by an aggregate amount not to exceed \$25.0 million. Availability under the 2010 Revolving Facility is subject to a borrowing base of 85% of eligible net accounts receivable. Borrowings under the ABL bear interest at a rate equal to, at the Company's option, either (a) LIBOR plus an applicable margin or (b) Base Rate, as defined, plus an applicable margin. The applicable margin in effect for borrowings during the two fiscal quarters following the date of the ABL was 2.25% with respect to Base Rate borrowings and 3.25% with respect to LIBOR borrowings. Beginning with third fiscal quarter following the date of the ABL, the applicable margin in effect for borrowings may be reduced to 2.00% with respect to Base Rate borrowings and 3.00% with respect to LIBOR borrowings, or increased to 2.50% with respect to Base Rate borrowings and 3.50% for LIBOR borrowings, subject to the company's fixed charge coverage ratio. In addition to paying interest on outstanding principal under the ABL, the Company is required to pay a commitment fee to the lenders under the 2010 Revolving Facility in respect of the unutilized commitments thereunder. If the average facility usage, as defined, for the most recently ended calendar month is greater than or equal to 50% of the aggregate commitments for such calendar month, the commitment fee shall be 0.50% per annum. Otherwise, the commitment fee shall be 0.75% per annum. The Company must also pay customary letter of credit fees. Principal amounts outstanding under the ABL are due and payable in full at maturity (December 2014).

At December 31, 2013, the Company had no outstanding 2010 Revolving Facility loans. At December 31, 2013, the Company had a borrowing base of \$73.9 million, net of outstanding letters of credit of \$4.9 million, primarily used as the collateral under the Company's workers' compensation programs, immediately available for borrowing under the ABL.

Debt Covenants

The indenture governing the 9 1/4% Notes contains a number of covenants that among other things, restrict, subject to certain exceptions, our ability and the ability of the Company's subsidiaries, to sell assets, incur additional indebtedness or issue preferred stock, pay dividends and distributions or repurchase our capital stock, create liens on assets, make investments, engage in mergers or consolidations, and engage in certain transactions with affiliates. At December 31, 2013, the Company was in compliance with all debt covenants for the 9 1/4% Notes that were subject to testing at that date.

The ABL agreement contains a number of covenants, including the requirement that the Company's fixed charge coverage ratio (as defined) cannot be less than 1.10 to 1.00 at the end of any measurement period. At December 31, 2013, the Company was in compliance with all ABL debt covenants that were subject to testing at that date.

6. Due to Parent

From time to time, the Company will receive cash advances from the Parent. The cash advances are generally for the purpose of funding business acquisitions of the Company. The amounts due to Parent are reduced by expenses paid by the Company on behalf of the Parent.

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

The Company also paid certain expenses incurred by the Parent in 2011, 2012 and 2013, resulting in a reduction of the amount due to Parent. The Parent does not charge interest to the Company on the amounts due to Parent.

7. Income Taxes

The provision for income taxes from continuing operations for the years ended December 31, 2011, 2012 and 2013 consists of the following (in millions):

	<u>2011</u>	<u>2012</u>	<u>2013</u>
Current:			
Federal	\$—	\$—	\$—
State	<u>0.3</u>	<u>1.0</u>	<u>0.9</u>
Total current	0.3	1.0	0.9
Deferred:			
Federal	2.5	1.8	(5.2)
State	<u>0.3</u>	<u>(0.6)</u>	<u>(2.0)</u>
Total deferred	2.8	1.2	(7.2)
Increase (decrease) in valuation allowance	<u>(1.7)</u>	<u>0.8</u>	<u>10.3</u>
Total	<u>\$ 1.4</u>	<u>\$ 3.0</u>	<u>\$ 4.0</u>

A reconciliation of the statutory federal income tax rate to the Company's effective income tax rate from continuing operations for the years ended December 31, 2011, 2012 and 2013 is as follows (dollars in millions):

	<u>2011</u>		<u>2012</u>		<u>2013</u>	
Federal statutory rate	\$ 2.7	34.0%	\$ 2.0	34.0%	\$ (5.4)	34.0%
State income taxes, net of federal income tax benefits	0.3	4.4	0.2	4.2	(0.7)	4.4
Permanent Items	0.5	6.8	0.5	7.9	0.2	(1.3)
Actualization	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	(0.2)	1.2
Non-controlling interests	(0.4)	(5.7)	(0.5)	(8.6)	(0.2)	1.2
Valuation allowance	<u>(1.7)</u>	<u>(21.8)</u>	<u>0.8</u>	<u>14.2</u>	<u>10.3</u>	<u>(64.8)</u>
Effective income tax rate	<u>\$ 1.4</u>	<u>17.7%</u>	<u>\$ 3.0</u>	<u>51.7%</u>	<u>\$ 4.0</u>	<u>(25.3)%</u>

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Deferred income taxes result from temporary differences in the recognition of assets, liabilities, revenues and expenses for financial accounting and tax purposes. Sources of these differences and the related tax effects at December 31, 2012 and 2013 are as follows (in millions):

	<u>2012</u>	<u>2013</u>
Deferred income tax liabilities:		
Depreciation and amortization	\$ 25.9	\$ 33.1
Joint ventures	4.9	0.7
Physician income guarantees	0.1	—
Provision for doubtful accounts	2.1	—
Other	0.6	0.3
	<u>33.6</u>	<u>34.1</u>
Total deferred tax liabilities		
Deferred income tax assets:		
Impaired assets	—	2.7
Organization costs	0.3	0.3
Professional liability claims	3.7	2.8
Accrued paid time off	2.8	2.2
Employee medical claims	0.9	0.8
Net operating losses	52.9	61.2
AMT credit	0.1	0.1
Employment credit	4.1	4.0
Accrued expenses	2.9	2.8
Charitable contributions	0.9	1.0
Provision for doubtful accounts	—	3.7
Other	0.5	0.3
	<u>69.1</u>	<u>81.9</u>
Total deferred income tax assets		
Valuation allowance	<u>(48.0)</u>	<u>(62.7)</u>
Net deferred income tax assets	<u>21.1</u>	<u>19.2</u>
Net deferred income tax liabilities	<u><u>\$(12.5)</u></u>	<u><u>\$(14.9)</u></u>

Because of uncertainties related to the realization of certain deferred tax assets, the Company recorded a valuation allowance of approximately \$48.0 million as of December 31, 2012 and \$62.7 million as of December 31, 2013.

The Company has federal and state net operating loss carryforwards of approximately \$135 million and \$243 million, respectively at December 31, 2013, which will begin to expire in 2028 and 2020. The Company also has Federal employment credits which will begin to expire in 2028. The Company is not currently under any federal or state tax examination. The Company reflected a tax benefit of \$0.7 million related to discontinued operations. This tax benefit is reflected in the net loss from discontinued operations.

The Company has adopted the provisions of FASB authoritative guidance regarding income tax uncertainties. Upon adoption of these provisions, the Company did not record a liability for uncertain tax deductions. At December 31, 2013, the liability for unrecognized tax benefits remains at zero. The Company's policy is to classify interest paid on an underpayment of income tax and related penalties as part of income tax expense.

8. Commitments and Contingencies

Employment Agreements

The Company has executed senior management agreements with eight of its senior executive officers. The agreements provide for minimum salary levels, adjusted based upon individual and Company performance criteria, as well as for

participation in bonus plans which are payable if specific management goals are met. The agreements also provide for severance benefits, if certain criteria are met, for a period of up to two years. The senior management agreements remain in place for each of the senior executive officers during their period of employment with the Company or any of its subsidiaries.

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Legal Proceedings and General Liability Claims

The Company is, from time to time, subject to claims and suits arising in the ordinary course of business, including claims for damages for personal injuries, medical malpractice, breach of management contracts, wrongful restriction of or interference with physicians' staff privileges and employment related claims. In certain of these actions, plaintiffs request punitive or other damages against the Company which may not be covered by insurance. The Company is currently not a party to any proceeding which, in management's opinion, would have a material adverse effect on the Company's business, financial condition or results of operations.

9. Leases

The Company leases various buildings and equipment under operating lease agreements. The leases expire at various times and have various renewal options.

The Company has certain leases that meet the lease capitalization criteria in accordance with FASB authoritative guidance. In accordance with the FASB authoritative guidance for leases, the capital leases have been recorded as an asset and liability at the lower of the net present value of the minimum lease payments or the fair value at the inception of the lease. The interest rate used in computing the net present value of the lease payments are based on either the Company's incremental borrowing rate at the inception of the lease or the interest rate implicit in the lease.

Operating lease rental expense relating primarily to the rental of buildings and equipment for the years ended December 31, 2011, 2012 and 2013 was approximately \$12.4 million, \$12.9 million and \$13.7 million, respectively.

Future minimum rental commitments under non-cancelable leases with an initial term in excess of one year at December 31, 2013, consist of the following (in millions):

	Capital Leases	Operating Leases
2014	\$ 46.9	\$ 9.3
2015	4.1	7.9
2016	4.1	5.1
2017	4.1	4.3
2018	—	3.8
Thereafter	—	9.6
Total minimum lease payments	\$ 59.2	\$ 40.0
Less: interest portion (interest rates from 3.8% to 7.9%)	(3.7)	
Long-term obligation under capital lease	<u>\$ 55.5</u>	

During the quarter ended December 31, 2012, the Company recorded an adjustment to income from continuing operations before income taxes of \$2.6 million related to the correction of prior period accounting for certain internal use software costs. Had the Company applied the appropriate accounting in prior periods, income from continuing operations before income taxes for the year ended December 31, 2011 and 2010 would have decreased by \$1.4 million and \$0.2 million, respectively. We have evaluated the materiality of the error from a quantitative and qualitative perspective and determined such to be immaterial to those prior periods.

10. Related-Party Transactions

On May 4, 2005, the Parent executed a Professional Services Agreement ("PSA") with GTCR Golder Rauner II, LLC ("GTCR"), whereby GTCR provides ongoing financial and management consulting to the Company until all investment funds managed by GTCR cease to own at least 10% of the collective Preferred Stock and Common Stock of the Parent. Under the PSA, the Company shall pay GTCR a placement fee of up to 1% of any debt financing in which GTCR is involved in raising the

debt financing.

Under the PSA, the Company shall pay GTCR an annual management fee equal to \$0.2 million upon the Company's achievement of EBITDA (as defined in the PSA) of \$30 million. In each of 2011, 2012 and 2013, the Company paid GTCR \$0.2 million in management fees under the PSA.

11. Retirement Plan

The Company has a defined contribution plan, effective December 1, 2005, covering all employees who have completed six months of service, as defined, and are age eighteen or older. Participants may contribute up to 99% of their annual compensation, as defined, up to a maximum of \$17,000 for participants under the age of 50 or \$22,000 for participants aged 50 years or older. Employer contributions are discretionary and amount to 100% of the first 2% of employee contributions and 25% on the next 4% of employee contributions, up to 3% of the individual participant's annual compensation, as defined. The Company did not authorize an employer contribution for 2011, 2012 or 2013.

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Table of Contents**Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)****12. Guarantor and Non-Guarantor Supplementary Information**

The Company's 9 1/4% Notes are jointly and severally guaranteed on an unsecured senior basis by substantially all of the Company's wholly-owned subsidiaries. The following presents the condensed consolidating financial information for the Company, as parent issuer, guarantor subsidiaries, non-guarantor subsidiaries, certain eliminations and the Company for the years ended December 31, 2011, 2012 and 2013 and as of December 31, 2012 and 2013:

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Capella Healthcare, Inc.
Condensed Consolidating Balance Sheets
December 31, 2012
(In Millions)

	<u>Parent Issuer</u>	<u>Guarantors</u>	<u>Non-Guarantors</u>	<u>Eliminations</u>	<u>Consolidated</u>
Assets					
Current assets:					
Cash and cash equivalents	\$ 39.5	\$ (4.4)	\$ (1.8)	\$ —	\$ 33.3
Accounts receivable, net	—	77.3	46.2	—	123.5
Inventories	—	14.1	10.7	—	24.8
Prepaid expenses and other current assets	1.4	2.3	1.2	—	4.9
Other receivables	3.5	2.6	0.5	—	6.6
Deferred tax assets	1.7	—	—	—	1.7
Total current assets	46.1	91.9	56.8	—	194.8
Property and equipment, net	10.4	312.4	150.8	—	473.6
Goodwill	136.0	—	—	—	136.0
Intangible assets, net	—	8.1	2.6	—	10.7
Investments in subsidiaries	12.6	—	—	(12.6)	—
Other assets, net	28.4	0.7	0.2	—	29.3
	<u>\$ 233.5</u>	<u>\$ 413.1</u>	<u>\$ 210.4</u>	<u>\$ (12.6)</u>	<u>\$ 844.4</u>
Liabilities and stockholder's deficit					
Current liabilities:					
Accounts payable	\$ 0.7	\$ 17.3	\$ 13.1	\$ —	\$ 31.1
Salaries and benefits payable	1.6	12.8	8.7	—	23.1
Accrued interest	23.3	—	—	—	23.3
Other accrued liabilities	8.6	5.9	6.4	—	20.9
Current portion of long-term debt	—	8.2	0.2	—	8.4
Total current liabilities	34.2	44.2	28.4	—	106.8
Long-term debt	—	405.9	137.5	—	543.4
Deferred income taxes	14.1	—	—	—	14.1
Other liabilities	29.6	0.5	0.2	—	30.3
Redeemable non-controlling interests	—	—	21.1	—	21.1
Due to (from) parent	237.4	(12.0)	(14.9)	—	210.5
Total stockholder's deficit	(81.8)	(25.5)	38.1	(12.6)	(81.8)
	<u>\$ 233.5</u>	<u>\$ 413.1</u>	<u>\$ 210.4</u>	<u>\$ (12.6)</u>	<u>\$ 844.4</u>

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Capella Healthcare, Inc.
Condensed Consolidating Balance Sheets
December 31, 2013
(In Millions)

	<u>Parent Issuer</u>	<u>Guarantors</u>	<u>Non-Guarantors</u>	<u>Eliminations</u>	<u>Consolidated</u>
Assets					
Current assets:					
Cash and cash equivalents	\$ 31.9	\$ (3.6)	\$ (1.9)	\$ —	\$ 26.4
Accounts receivable, net	—	74.9	51.4	—	126.3
Inventories	—	14.1	10.2	—	24.3
Prepaid expenses and other current assets	1.4	2.1	1.5	—	5.0
Other receivables	3.2	2.6	0.8	—	6.6
Deferred tax assets	2.5	—	—	—	2.5
Assets held for sale	—	13.1	—	—	13.1
Total current assets	39.0	103.2	62.0	—	204.2
Property and equipment, net	1.7	298.3	156.1	—	456.1
Goodwill	133.6	—	—	—	133.6
Intangible assets, net	—	10.0	3.2	—	13.2
Investments in subsidiaries	(6.1)	—	—	6.1	—
Other assets, net	22.8	0.9	—	—	23.7
	<u>\$ 191.0</u>	<u>\$ 412.4</u>	<u>\$ 221.3</u>	<u>\$ 6.1</u>	<u>\$ 830.8</u>
Liabilities and stockholder's deficit					
Current liabilities:					
Accounts payable	\$ 0.8	\$ 15.0	\$ 12.7	\$ —	\$ 28.5
Salaries and benefits payable	2.9	11.4	9.5	—	23.8
Accrued interest	23.3	—	—	—	23.3
Other accrued liabilities	8.2	14.0	10.5	—	32.7
Current portion of long-term debt	—	48.2	1.4	—	49.6
Liabilities held for sale	—	1.9	—	—	1.9
Total current liabilities	35.2	90.5	34.1	—	159.8
Long-term debt	—	366.0	141.8	—	507.8
Deferred income taxes	17.3	—	—	—	17.3
Other liabilities	27.6	0.5	0.3	—	28.4
Redeemable non-controlling interests	—	—	21.4	—	21.4
Due to (from) parent	225.7	5.1	(19.9)	—	210.9
Total stockholder's deficit	(114.8)	(49.7)	43.6	6.1	(114.8)
	<u>\$ 191.0</u>	<u>\$ 412.4</u>	<u>\$ 221.3</u>	<u>\$ 6.1</u>	<u>\$ 830.8</u>

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Capella Healthcare, Inc.
Condensed Consolidating Statements of Operations
For the Year Ended December 31, 2011
(In Millions)

	<u>Parent Issuer</u>	<u>Guarantors</u>	<u>Non-Guarantors</u>	<u>Eliminations</u>	<u>Consolidated</u>
Revenue before provision for bad debts	\$ —	\$ 426.7	\$ 297.0	\$ —	\$ 723.7
Provision for bad debts	(0.8)	(40.5)	(31.0)	—	(72.3)
Revenue	(0.8)	386.2	266.0	—	651.4
Costs and expenses					
Salaries and benefits	8.0	189.7	116.2	—	313.9
Supplies	0.1	57.4	50.8	—	108.3
Other operating expenses	6.0	83.8	54.9	—	144.7
Other income	—	(5.7)	(1.5)	—	(7.2)
Equity in (earnings) losses of affiliates	10.2	—	—	(10.2)	—
Management fees	(15.8)	10.6	5.4	—	0.2
Interest, net	4.3	34.7	12.1	—	51.1
Depreciation and amortization	0.2	19.9	11.7	—	31.8
Total costs and expenses	13.0	390.1	249.6	(10.2)	642.8
Income (loss) from continuing operations before income taxes	(13.8)	(4.2)	16.4	10.2	8.6
Income taxes	0.7	0.6	0.1	—	1.4
Income (loss) from continuing operations	(14.5)	(4.8)	16.3	10.2	7.2
Income (loss) from discontinued operations	—	(20.6)	0.1	—	(20.5)
Net income (loss)	(14.5)	(25.4)	16.4	10.2	(13.3)
Less: Net income attributable to non-controlling interests	—	—	1.2	—	1.2
Net income (loss) attributable to Capella Healthcare, Inc.	\$ (14.5)	\$ (25.4)	\$ 15.2	\$ 10.2	\$ (14.5)

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Capella Healthcare, Inc.
Condensed Consolidating Statements of Operations
For the Year Ended December 31, 2012
(In Millions)

	<u>Parent Issuer</u>	<u>Guarantors</u>	<u>Non-Guarantors</u>	<u>Eliminations</u>	<u>Consolidated</u>
Revenue before provision for bad debts	\$ —	\$ 476.3	\$ 326.0	\$ —	\$ 802.3
Provision for bad debts	—	(44.3)	(39.8)	—	(84.1)
Revenue	—	432.0	286.2	—	718.2
Costs and expenses					
Salaries and benefits	15.2	190.4	127.6	—	333.2
Supplies	—	60.2	54.6	—	114.8
Other operating expenses	10.3	102.4	65.0	—	177.7
Other income	—	(1.3)	(5.1)	—	(6.4)
Equity in (earnings) losses of affiliates	0.4	—	—	(0.4)	—
Management fees	(19.4)	12.3	7.3	—	0.2
Interest, net	4.7	35.9	12.5	—	53.1
Depreciation and amortization	0.2	23.7	13.9	—	37.8
Total costs and expenses	11.4	423.6	275.8	(0.4)	710.4
Income (loss) from continuing operations before income taxes	(11.4)	8.4	10.4	0.4	7.8
Income taxes	2.7	0.1	0.2	—	3.0
Income (loss) from continuing operations	(14.1)	8.3	10.2	0.4	4.8
Loss from discontinued operations	—	(16.7)	(0.9)	—	(17.6)
Net income (loss)	(14.1)	(8.4)	9.3	0.4	(12.8)
Less: Net income attributable to non-controlling interests	—	—	1.3	—	1.3
Net income (loss) attributable to Capella Healthcare, Inc.	\$ (14.1)	\$ (8.4)	\$ 8.0	\$ 0.4	\$ (14.1)

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Capella Healthcare, Inc.
Condensed Consolidating Statements of Operations
For the Year Ended December 31, 2013
(In Millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenue before provision for bad debts	\$ —	\$ 486.0	\$ 342.5	\$ —	\$ 828.5
Provision for bad debts	—	(57.0)	(49.2)	—	(106.2)
Revenue	—	429.0	293.3	—	722.3
Costs and expenses					
Salaries and benefits	15.5	200.4	126.9	—	342.8
Supplies	—	63.8	59.3	—	123.1
Other operating expenses	8.2	107.1	70.2	—	185.5
Other income	—	(7.9)	(4.7)	—	(12.6)
Equity in (earnings) losses of affiliates	18.6	—	—	(18.6)	—
Management fees	(18.6)	12.0	6.8	—	0.2
Interest, net	5.2	36.3	13.5	—	55.0
Depreciation and amortization	0.4	28.2	15.6	—	44.2
Total costs and expenses	29.3	439.9	287.6	(18.6)	738.2
Income (loss) from continuing operations before income taxes	(29.3)	(10.9)	5.7	18.6	(15.9)
Income taxes	3.1	0.4	0.5	—	4.0
Income (loss) from continuing operations	(32.4)	(11.3)	5.2	18.6	(19.9)
Income (loss) from discontinued operations	0.6	(12.8)	0.8	—	(11.4)
Net income (loss)	(31.8)	(24.1)	6.0	18.6	(31.3)
Less: Net income attributable to non-controlling interests	—	—	0.5	—	0.5
Net income (loss) attributable to Capella Healthcare, Inc.	\$ (31.8)	\$ (24.1)	\$ 5.5	\$ 18.6	\$ (31.8)

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Capella Healthcare, Inc.
Condensed Consolidating Statements of Cash Flows
For the Year Ended December 31, 2011
(In Millions)

	<u>Parent Issuer</u>	<u>Guarantors</u>	<u>Non-Guarantors</u>	<u>Eliminations</u>	<u>Consolidated</u>
Operating activities:					
Net income (loss)	\$ (14.5)	\$ (25.4)	\$ 16.4	\$ 10.2	\$ (13.3)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:					
Equity in earnings of affiliates	10.2	—	—	(10.2)	—
Loss from discontinued operations	—	20.6	(0.1)	—	20.5
Depreciation and amortization	0.2	19.9	11.7	—	31.8
Amortization of loan costs and bond discount	1.9	0.5	0.4	—	2.8
Provision for bad debts	0.8	40.5	31.0	—	72.3
Deferred income taxes	1.2	—	—	—	1.2
Stock-based compensation	0.8	—	—	—	0.8
Changes in operating assets and liabilities, net of effect of acquisitions:					
Accounts receivable, net	(0.8)	(41.3)	(30.8)	—	(72.9)
Inventories	—	(2.1)	(0.5)	—	(2.6)
Prepaid expenses and other current assets	(0.7)	(4.4)	(0.9)	—	(6.0)
Accounts payable and other current liabilities	3.2	1.3	2.0	—	6.5
Accrued salaries	(0.7)	0.1	(0.4)	—	(1.0)
Accrued interest	(0.4)	—	—	—	(0.4)
Other	(0.1)	(0.2)	(0.4)	—	(0.7)
Net cash provided by operating activities – continuing operations	1.1	9.5	28.4	—	39.0
Net cash provided by operating activities – discontinued operations	—	3.7	0.3	—	4.0
Net cash provided by operating activities	1.1	13.2	28.7	—	43.0
Investing activities:					
Purchases of property and equipment, net	(0.4)	(16.9)	(14.0)	—	(31.3)
Acquisition of healthcare business	(2.7)	—	(31.4)	—	(34.1)
Proceeds from disposition of healthcare businesses	—	20.5	—	—	20.5
Change in other assets	—	(1.4)	(0.4)	—	(1.8)
Net cash provided by (used in) investing activities – continuing operations	(3.1)	2.2	(45.8)	—	(46.7)
Net cash used in investing activities – discontinued operations	—	(2.9)	—	—	(2.9)
Net cash used in investing activities	(3.1)	(0.7)	(45.8)	—	(49.6)
Financing activities:					

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Advances to (from) Parent	(4.6)	(9.2)	17.6	—	3.8
Repurchases of non-controlling interests	—	—	(0.3)	—	(0.3)
Distributions to non-controlling interests	—	—	(1.0)	—	(1.0)
Net cash provided by (used in) financing activities – continuing operations	(4.6)	(9.2)	16.3	—	2.5
Net cash used in financing activities – discontinued operations	—	(1.8)	—	—	(1.8)
Net cash provided by (used in) financing activities	(4.6)	(11.0)	16.3	—	0.7
Change in cash and cash equivalents	(6.6)	1.5	(0.8)	—	(5.9)
Cash and cash equivalents at beginning of year	55.0	(4.2)	(2.5)	—	48.3
Cash and cash equivalents at end of year	<u>\$ 48.4</u>	<u>\$ (2.7)</u>	<u>\$ (3.3)</u>	<u>\$ —</u>	<u>\$ 42.4</u>

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Capella Healthcare, Inc.
Condensed Consolidating Statements of Cash Flows
For the Year Ended December 31, 2012
(In Millions)

	<u>Parent Issuer</u>	<u>Guarantors</u>	<u>Non-Guarantors</u>	<u>Eliminations</u>	<u>Consolidated</u>
Operating activities:					
Net income (loss)	\$ (14.1)	\$ (8.4)	\$ 9.3	\$ 0.4	\$ (12.8)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:					
Equity in earnings of affiliates	0.4	—	—	(0.4)	—
Loss from discontinued operations	—	17.8	(0.2)	—	17.6
Depreciation and amortization	0.2	23.7	13.9	—	37.8
Amortization of loan costs and bond discount	3.0	0.5	0.4	—	3.9
Provision for bad debts	—	44.3	39.8	—	84.1
Deferred income taxes	2.0	—	—	—	2.0
Stock-based compensation	1.0	—	—	—	1.0
Changes in operating assets and liabilities, net of effect of acquisitions:					
Accounts receivable, net	—	(54.7)	(42.5)	—	(97.2)
Inventories	—	(0.4)	0.1	—	(0.3)
Prepaid expenses and other current assets	(2.7)	2.1	0.9	—	0.3
Accounts payable and other current liabilities	0.9	0.5	5.7	—	7.1
Accrued salaries	(0.1)	1.0	0.3	—	1.2
Other	0.2	0.1	1.5	—	1.8
Net cash provided by (used in) operating activities – continuing operations	(9.2)	26.5	29.2	—	46.5
Net cash used in operating activities – discontinued operations	—	(2.7)	0.2	—	(2.5)
Net cash provided by (used in) operating activities	(9.2)	23.8	29.4	—	44.0
Investing activities:					
Acquisition of healthcare businesses	(26.0)	—	—	—	(26.0)
Purchases of property and equipment, net	(16.0)	(8.5)	(8.4)	—	(32.9)
Proceeds from disposition of healthcare businesses	12.4	—	—	—	12.4
Net cash used in investing activities – continuing operations	(29.6)	(8.5)	(8.4)	—	(46.5)
Net cash used in investing activities – discontinued operations	—	(0.9)	—	—	(0.9)
Net cash used in investing activities	(29.6)	(9.4)	(8.4)	—	(47.4)
Financing activities:					
Payments on capital leases and other					

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obligations	—	(2.7)	—	—	(2.7)
Payment of debt issue costs	—	(0.2)	—	—	(0.2)
Advances to (from) Parent	29.9	(13.6)	(16.7)	—	(0.4)
Repurchase of non-controlling interests	—	—	(1.1)	—	(1.1)
Distributions to non-controlling interests	—	—	(1.7)	—	(1.7)
Net cash provided by (used in) financing activities – continuing operations	29.9	(16.5)	(19.5)	—	(6.1)
Net cash provided by financing activities – discontinued operations	—	0.4	—	—	0.4
Net cash provided by (used in) financing activities	29.9	(16.1)	(19.5)	—	(5.7)
Change in cash and cash equivalents	(8.9)	(1.7)	1.5	—	(9.1)
Cash and cash equivalents at beginning of year	48.4	(2.7)	(3.3)	—	42.4
Cash and cash equivalents at end of year	<u>\$ 39.5</u>	<u>\$ (4.4)</u>	<u>\$ (1.8)</u>	<u>\$ —</u>	<u>\$ 33.3</u>

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Capella Healthcare, Inc.
Notes to Consolidated Financial Statements (continued)

Capella Healthcare, Inc.
Condensed Consolidating Statements of Cash Flows
For the Year Ended December 31, 2013
(In Millions)

	<u>Parent Issuer</u>	<u>Guarantors</u>	<u>Non-Guarantors</u>	<u>Eliminations</u>	<u>Consolidated</u>
Operating activities:					
Net income (loss)	\$ (31.8)	\$ (24.1)	\$ 6.0	\$ 18.6	\$ (31.3)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:					
Equity in earnings of affiliates	18.6	—	—	(18.6)	—
Loss (income) from discontinued operations	(0.6)	12.8	(0.8)	—	11.4
Depreciation and amortization	0.4	28.2	15.6	—	44.2
Amortization of loan costs	3.1	0.7	0.2	—	4.0
Provision for bad debts	—	57.0	49.2	—	106.2
Deferred income taxes	3.1	—	—	—	3.1
Stock-based compensation	0.8	—	—	—	0.8
Changes in operating assets and liabilities, net of effect of acquisitions:					
Accounts receivable, net	(0.3)	(58.9)	(54.4)	—	(113.6)
Inventories	—	(1.1)	0.5	—	(0.6)
Prepaid expenses and other current assets	0.3	—	(0.6)	—	(0.3)
Accounts payable and other current liabilities	0.6	6.9	3.7	—	11.2
Accrued salaries	0.5	(0.6)	0.8	—	0.7
Other	0.5	(2.3)	(0.3)	—	(2.1)
Net cash provided by (used in) operating activities – continuing operations	(4.8)	18.6	19.9	—	33.7
Net cash provided by (used in) operating activities – discontinued operations	—	(3.7)	0.8	—	(2.9)
Net cash provided by (used in) operating activities	(4.8)	14.9	20.7	—	30.8
Investing activities:					
Purchases of property and equipment, net	(0.2)	(11.1)	(15.0)	—	(26.3)
Proceeds from disposition of hospital	—	1.6	—	—	1.6
Net cash used in investing activities – continuing operations	(0.2)	(9.5)	(15.0)	—	(24.7)
Net cash used in investing activities – discontinued operations	—	(2.1)	—	—	(2.1)
Net cash used in investing activities	(0.2)	(11.6)	(15.0)	—	(26.8)
Financing activities:					
Payments on capital leases and other obligations	—	(9.2)	(0.6)	—	(9.8)
Advances to (from) Parent	(2.6)	6.7	(3.8)	—	0.3

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Repurchase of non-controlling interests	—	—	(0.2)	—	(0.2)
Distributions to non-controlling interests	—	—	(1.2)	—	(1.2)
Net cash used in financing activities	(2.6)	(2.5)	(5.8)	—	(10.9)
Change in cash and cash equivalents	(7.6)	0.8	(0.1)	—	(6.9)
Cash and cash equivalents at beginning of year	39.5	(4.4)	(1.8)	—	33.3
Cash and cash equivalents at end of year	<u>\$ 31.9</u>	<u>\$ (3.6)</u>	<u>\$ (1.9)</u>	<u>\$ —</u>	<u>\$ 26.4</u>

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Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, in the City of Franklin, State of Tennessee, as of the 11th day of March, 2014.

CAPELLA HEALTHCARE, INC.

By: /s/ Michael A. Wiechart

Michael A. Wiechart
President and Chief Executive Officer

Pursuant to the requirements of the Securities Act of 1934, this report has been signed below by the following persons on behalf of the registrant in the capacities and on the date indicated.

<u>Signature</u>	<u>Title</u>	<u>Date</u>
/s/ Michael A. Wiechart Michael A. Wiechart	President and Chief Executive Officer (Principal Executive Officer)	March 11, 2014
/s/ Denise W. Warren Denise W. Warren	Executive Vice President, Chief Financial Officer and Treasurer (Principal Financial Officer and Principal Accounting Officer)	March 11, 2014
/s/ J. Thomas Anderson J. Thomas Anderson	Director	March 11, 2014
/s/ Robert Z. Hensley Robert Z. Hensley	Director	March 11, 2014
/s/ David S. Katz David S. Katz	Director	March 11, 2014
/s/ Joseph P. Nolan Joseph P. Nolan	Director	March 11, 2014
/s/ Daniel S. Slipkovich Daniel S. Slipkovich	Director	March 11, 2014

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<u>Exhibit Number</u>	<u>Description</u>
3.1	Certificate of Incorporation of Capella Healthcare, Inc. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
3.2	By-Laws of Capella Healthcare, Inc. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
4.1	Indenture, dated as of June 28, 2010, among Capella Healthcare, Inc., the Guarantors named therein and U.S. Bank National Association, as Trustee (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
4.2	Form of 9 1/4% Senior Notes due 2017 (included in Exhibit 4.1) (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
4.3	Form of Supplemental Indenture to add a Guaranty Subsidiary (incorporated by reference from exhibits to the Quarterly Report on Form 10-Q filed by Capella Healthcare, Inc. on November 2, 2012)
4.4	Registration Rights Agreement, dated as of June 28, 2010, among Capella Healthcare, Inc., the Guarantors party thereto, and Banc of America Securities LLC, as representatives of the initial purchasers named therein (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.1	Stock Purchase Agreement, dated as of May 4, 2005, by and among Capella Holdings, Inc., GTCR Fund VIII, L.P., GTCR Fund VIII/B, L.P., GTCR Co-Invest II, L.P. and the other investors named therein (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.2	Supplement No. 1 to the Stock Purchase Agreement, dated as of April, 2007, by and among Capella Holdings, Inc., GTCR Fund VIII, L.P., GTCR Fund VIII/B, L.P., GTCR Co-Invest II, L.P. and the other investors named therein (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.3	Amendment and Supplement No. 2 to the Stock Purchase Agreement, dated as of February 29, 2008, by and among Capella Holdings, Inc., GTCR Fund VIII, L.P., GTCR Fund VIII/B, L.P., GTCR Co-Invest II, L.P. and the other investors named therein (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.4	Stockholders Agreement, dated as of May 4, 2005, by and among Capella Holdings, Inc., GTCR Fund VIII, L.P., GTCR Fund VIII/B, L.P., GTCR Co-Invest II, L.P. and the other investors named therein (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.5	Amendment No. 1 to the Stockholders Agreement, dated as of February 29, 2008, by and among Capella Holdings, Inc., GTCR Fund VIII, L.P., GTCR Fund VIII/B, L.P., GTCR Co-Invest II, L.P. and the other investors named therein (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.6	Registration Rights Agreement, dated as of May 4, 2005, by and among Capella Holdings, Inc., GTCR Fund VIII, L.P., GTCR Fund VIII/B, L.P., GTCR Co-Invest II, L.P. and the other investors named therein (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.7	Professional Services Agreement, dated as of May 4, 2005, between GTCR Golder Rauner II, LLC and Capella

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Healthcare, Inc. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)

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<u>Exhibit Number</u>	<u>Description</u>
10.8	Amendment No. 1 to Professional Services Agreement between GTCR Golder Rauner II, LLC and Capella Healthcare, Inc., dated as of November 30, 2005 (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.9	Loan and Security Agreement, dated June 28, 2010, by and among Capella Healthcare, Inc. and certain borrowing subsidiaries as Borrowers, certain guarantying subsidiaries as Guarantors, certain financial institutions as Lenders, Bank of America, N.A. as Agent and Collateral Agent, Citibank, N.A. as Syndication Agent, Barclays Bank PLC and General Electric Capital Corporation as Co-Documentation Agents and Bank of America Securities LLC and Citigroup Global Markets Inc. as Co-Lead Arrangers and Co-Book Managers (incorporated by reference from exhibits to the Registration Statement on Form S-4/A filed by Capella Healthcare, Inc. on September 23, 2011, File No. 333-175188) **
10.10	Form of Joinder to Loan and Security Agreement (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.11	Consent Agreement and Amendment No. 1 to Loan Agreement, dated January 27, 2012, by and among Capella Healthcare, Inc. and certain borrowing subsidiaries as Borrowers, certain guarantying subsidiaries as Subsidiary Guarantors, certain financial institutions as Lenders, and Bank of America, N.A. as Agent (incorporated by reference from exhibits to the Quarterly Report on Form 10-Q filed by Capella Healthcare, Inc. on August 3, 2012)
10.12	Consent Agreement and Amendment No. 2 to Loan Agreement, dated June 29, 2012, by and among Capella Healthcare, Inc. and certain borrowing subsidiaries as Borrowers, certain guarantying subsidiaries as Subsidiary Guarantors, certain financial institutions as Lenders, and Bank of America, N.A. as Agent (incorporated by reference from exhibits to the Quarterly Report on Form 10-Q filed by Capella Healthcare, Inc. on August 3, 2012)
10.13	Senior Management Agreement, dated as of May 4, 2005, by and among Capella Holdings, Inc., Capella Healthcare, Inc. and Daniel S. Slipkovich (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.14	Amendment No. 1 to Senior Management Agreement, dated as of May 12, 2006, by and among Capella Holdings, Inc., Capella Healthcare, Inc., Daniel S. Slipkovich and GTCR Fund VIII, L.P. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.15	Senior Management Agreement, dated as of May 4, 2005, by and among Capella Holdings, Inc., Capella Healthcare, Inc. and James Thomas Anderson (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.16	Amendment No. 1 to Senior Management Agreement, dated as of May 12, 2006, by and among Capella Holdings, Inc., Capella Healthcare, Inc., James Thomas Anderson and GTCR Fund VIII, L.P. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.17	Amendment No. 2 to Senior Management Agreement, dated as of September 1, 2010, by and among Capella Holdings, Inc., Capella Healthcare, Inc., James Thomas Anderson and GTCR Fund VIII, L.P. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.18	Amendment No. 3 to Senior Management Agreement, dated August 31, 2013, by and among Capella Holdings, Inc., Capella Healthcare, Inc. and James Thomas Anderson (incorporated by reference from exhibits to the Quarterly Report on Form 10-Q filed by Capella Healthcare, Inc., on November 8, 2013, File No. 333-175188)*
10.19	Senior Management Agreement, dated May 4, 2005, by and among Capella Holdings, Inc., Capella Healthcare, Inc. and David Andrew Slusser (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed

by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *

- 10.20 Amendment No. 1 to Senior Management Agreement, dated as of May 12, 2006, by and among Capella Holdings, Inc., Capella Healthcare, Inc., David Andrew Slusser and GTCR Fund VIII, L.P. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
- 10.21 Senior Management Agreement, dated as of October 17, 2005, by and among Capella Holdings, Inc., Capella Healthcare, Inc. and Denise Wilder Warren (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
- 10.22 Amendment No. 1 to Senior Management Agreement, dated as of May 12, 2006, by and among Capella Holdings, Inc., Capella Healthcare, Inc., Denise Wilder Warren and GTCR Fund VIII, L.P. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *

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<u>Exhibit Number</u>	<u>Description</u>
10.23	Senior Management Agreement, dated as of May 26, 2009, by and among Capella Holdings, Inc., Capella Healthcare, Inc. and Michael Wiechart (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.24	Form of Amendment No. 1 to Senior Management Agreement, dated as of August 24, 2011, by and among Capella Holdings, Inc., Capella Healthcare, Inc., Michael Wiechart and GTCR Fund VIII, L.P. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *

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<u>Exhibit Number</u>	<u>Description</u>
10.25	Capella Holdings, Inc. 2006 Stock Option Plan (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.26	Capella Holdings, Inc. Deferred Compensation Plan (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188) *
10.27	Computer and Data Processing Services Agreement, effective February 21, 2011, by and among HCA-Information Technology & Services, Inc. and Capella Healthcare, Inc. (incorporated by reference from exhibits to the Registration Statement on Form S-4/A filed by Capella Healthcare, Inc. on September 23, 2011, File No. 333-175188) **
10.28	Amendment No. 001 to Computer and Data Processing Services Agreement, effective May 5, 2011, by and among HCA-Information Technology & Services, Inc. and Capella Healthcare, Inc. (incorporated by reference from exhibits to the Registration Statement on Form S-4/A filed by Capella Healthcare, Inc. on September 23, 2011, File No. 333-175188) **
10.29	Lease Agreement, dated April 3, 2007, by and among Muskogee Medical Center Authority, d/b/a Muskogee Regional Medical Center, Muskogee Regional Medical Center, LLC, and Capella Healthcare, Inc. (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.30	Form of Redemption Agreement (incorporated by reference from exhibits to the Registration Statement on Form S-4 filed by Capella Healthcare, Inc. on June 28, 2011, File No. 333-175188)
10.31	Senior Management Agreement, dated September 20, 2011, by and among Capella Holdings, Inc., Capella Healthcare, Inc. and Neil W. Kunkel (incorporated by reference from exhibits to the Quarterly Report on Form 10-Q filed by Capella Healthcare, Inc. on November 11, 2011) *
21	Subsidiaries of Registrant
31.1	Certification of the Chief Executive Officer of Capella Healthcare, Inc. pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of the Chief Financial Officer of Capella Healthcare, Inc. pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of the Chief Executive Officer of Capella Healthcare, Inc. pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of the Chief Financial Officer of Capella Healthcare, Inc. pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101.INS	XBRL Instance Document***
101.SCH	XBRL Taxonomy Extension Schema Document***
101.CAL	XBRL Taxonomy Calculation Linkbase Document***
101.DEF	XBRL Taxonomy Definition Linkbase Document***
101.LAB	XBRL Taxonomy Label Linkbase Document***
101.PRE	XBRL Taxonomy Presentation Linkbase Document***

* Management compensatory plan or arrangement.

** Certain information has been omitted pursuant to a confidential treatment request filed with the SEC.

*** Furnished electronically herewith

Tab 14

Attachment C
Contribution to the Orderly Development of Health Care – 5
Performance Improvement Plan



River Park Hospital

In partnership with Saint Thomas Health

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SCOPE:

- All components of the organization, including contracted services, are included in the organization's Performance Improvement Program. The program will include, but not be limited to:
 - An ongoing process demonstrating measurable improvements in indicators for which there is evidence that health outcomes will be improved; and
 - Measurement, analysis and tracking of quality indicators, including adverse patient events, and other aspects of performance to assess processes of care, treatment, services and operations provided.
- The PI Plan includes program description of:
 - Responsibilities and Program Framework
 - Planning
 - Designing New or Modified Processes
 - Data Use, Analysis and Understanding Variation
 - Methodologies Used for Improvement and Analysis of Work Processes
 - Establishing Priorities and Prioritization Criteria
 - Change Management, Implementing Change and Sustaining Improvement
 - Performance Improvement Projects and Project Teams
 - Staffing Considerations
 - Patient Safety (with references to the organization's *Patient Safety Plan*)
 - Communication
 - Education and Training
 - Confidentiality
 - Program Evaluation

PURPOSE:

The purpose of this Plan is to provide a framework for:

- Developing, implementing and maintaining an effective ongoing organization-wide, data-driven performance improvement program.
- Supporting the organization's:
 - Mission;
 - Strategic Plan and Strategic Initiatives; and
 - Patient Safety Program.
- Including all department and services of the organization in the program, including contracted and other services.
- Identifying performance improvement and safety priorities, including those related to improving health outcomes and the prevention and reduction of medical errors.
- Defining responsibilities for full and ongoing implementation of the program.



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POLICY:

RESPONSIBILITIES AND PROGRAM FRAMEWORK

Performance Improvement Council

Membership:

- Core Members: One Board member, CEO, CNO, CQO, two medical staff members, Director of Pharmacy, Director of Human Resources, Director of Infection Control, Risk Manager and the Patient Safety Officer.
- Adhoc Members: Director of Staff Education, Director of IS, and other Directors as needed

Meeting Requirements: The Council will meet at least ten (10) times per year or more frequently as needed.

Responsibilities:

- Oversees, coordinates, and directs the performance improvement activities.
- Patient Safety: (see *Patient Safety Plan* for details)
 - Functions as the oversight committee for patient safety
 - Collaborates effectively with the organization's EOC to identify and reduce medical errors and improve patient health outcomes.
- Recommends priorities for performance improvement and patient safety activities to the MEC and the Board based on ongoing and annual reviews.
- Establishes specific, measurable goals for projects.
- Through aggregation and analysis of data collected:
 - Monitors the effectiveness and safety of services and quality of care provided; and
 - Identifies opportunities for improvement and changes leading to improvement.
- Recommends to the Board the frequency and detail of data collection on required measures/indicators, as needed.
- Supports performance improvement and patient safety activities.
- Regularly reviews recommendations for performance improvement and patient safety activities based on trends and patterns identified by committees, departments and services.
- Assigns process improvement activities to a specific department.
- Prepares ongoing summary reports on performance improvement activities for the MEC and Board.
- Annually evaluates the Performance Improvement Program.
- Communicates clearly defined expectations for performance improvement, safety and defined priorities to Medical Staff, Administration, Board, Management and staff.
- Verifies an evaluation of the culture of safety and quality is conducted on an ongoing basis as described in the *Patient Safety Plan*.



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Medical Staff

Responsibilities:

1. Accountable for ensuring the following:
 - a. An ongoing program for performance improvement is defined, implemented and maintained; and
 - b. An ongoing program for patient safety, including the reduction of medical errors is defined, implemented and maintained (See *Patient Safety Program Plan* for details).
2. Responsible for the quality of medical care provided to patients.
3. Involved in activities to measure, assess, and improve performance and patient safety on an organization wide basis for clinical and non-clinical processes, which require medical staff leadership participation, including, but not limited to:
 - a. Credentialing and privileging processes.
 - b. Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation processes.
 - c. Evaluation of medical staff and AHP processes related to assessment and treatment of patients, use of medications, use of blood and blood components, operative and other procedures placing patients at risk, efficiency of clinical practice patterns, significant departures from established clinical practice patterns, autopsy reviews, and the accuracy, timeliness and legible completion of medical records.
4. Identified medical staff members are active participants on the Performance Improvement Council.
5. Other responsibilities as defined in the *Medical Staff Bylaws and Rules and Regulations*.

Administrative Leaders

Responsibilities:

1. Accountable for ensuring the following:
 - a. An ongoing program for performance improvement is defined, implemented and maintained; and
 - b. An ongoing program for patient safety, including the reduction of medical errors is defined, implemented and maintained (See *Patient Safety Program Plan* for details)
2. Supporting teams chartered by the Performance Improvement Council.
3. Providing an opportunity for all individuals within the organization to participate in safety and quality initiatives.
4. Providing education that focuses on safety and quality for all individuals.
5. Establishing a team approach among all staff at all levels.
6. Encouraging individuals to openly discuss issues of safety and quality.
7. Fostering a blame-free culture and an environment of collaboration both internally and externally in their departments.



River Park Hospital

In partnership with Saint Thomas Health

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Quality Department

Responsibilities:

1. Serves as a resource to the Performance Improvement Council, PI Teams, the Medical Staff and all organization departments and services.
2. Assists in defining measurable indicators to improve health outcomes and monitor performance.
3. Assists in analyzing reports and indicators to identify patterns and trends requiring improvement activities, including patient safety initiatives.
4. Monitors the effectiveness and safety of services and quality of care, in collaboration with the organization's Risk Management Department and Patient Safety Program.
5. Supports the organization in meeting CMS and Joint Commission requirements related to quality assurance, performance improvement and patient safety.
6. Reports identified patterns and trends, which may require a performance improvement initiative to the effected departments and the Performance Improvement Council.
7. Maintains and monitors the reporting schedule of key reports and projects.

Note: Any Board member, employee, medical staff member or volunteer may make a suggestion for a Performance Improvement or Patient Safety project by contacting the PI Department.

Managers

Responsibilities:

8. Accountable for ensuring the following:
 - c. An ongoing program for performance improvement is implemented and maintained; and
 - d. An ongoing program for patient safety, including the reduction of medical errors is, implemented and maintained (See *Patient Safety Program Plan* for details).
9. Oversight of ongoing performance improvement and patient safety activities in their departments, including data aggregation and analysis of unit/department specific quality indicators.
10. Acting on recommendations generated by performance improvement and patient safety activities (many of these activities will interface with other departments and the Medical Staff).
11. Fostering a blame-free culture and an environment of collaboration both internally and externally in their departments.
12. Establishing performance improvement activities in conjunction with other departments, as needed for those activities that do not require a large cross-functional team.
13. Submitting an annual evaluation of unit/department specific performance improvement to the PI Department.
14. Providing an opportunity for all individuals within the department to participate in safety and quality initiatives.
15. Establishing a team approach among all staff at all levels.
16. Encouraging individuals to openly discuss issues of safety and quality



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Employees

The organization recognizes the role of the Individual employee as critical to the success of performance improvement and patient safety initiatives.

Responsibilities:

17. Reporting adverse events and other processes related to performance improvement and patient safety.
18. Actively participating in teams and special projects as requested.
19. Implementing process improvement and patient safety initiatives as defined by the organization.
20. Contributing to improvement efforts.

PLANNING

- Safety and quality planning will be organization-wide.
- Planning activities will:
 - Focus on patient safety and healthcare quality;
 - Support a culture of safety and quality;
 - Be systematic and involve designated individuals and information sources;
 - Determine resources needed to provide safety and quality in the care, treatment and services provided; and
 - Adapt to changes in the environment.

DESIGNING NEW OR MODIFIED PROCESSES

The organization designs new or modified services, policies or procedures with quality in mind, including consideration of underlying systems to minimize the risk of the effects on the patients. In the design or redesign of processes, functions, or services the following information, when available and relevant is considered:

- An expert within the organization is assigned the responsibility of developing the process.
- Key individuals, who will own the process when it is completed, are assigned to a design team led by the expert.
- Results of performance improvement activities are considered.
- This design team develops the process with the following concepts in mind:
 - It is consistent with the organization's mission, vision, values, goals and Strategic Initiatives;
 - It involves staff and patients, as appropriate;
 - It meets the needs and expectations of key customers (individuals served, patients, staff and others);



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- It is clinically sound, current and evidenced-based (for instance, uses information from relevant literature and clinical standard);
- It is consistent with sound business practices;
- It incorporates available information from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel events in order to minimize risks to patients affected by the new or redesigned process, function, or service;
- It incorporated information about sentinel events;
- It includes analysis and/or pilot testing to determine whether the proposed design/redesign is an improvement;
- It incorporates the results of performance improvement activities, including monitoring of the effectiveness of the designed/redesigned process; and
- Utilizes the FMEA process, as appropriate.
- Performance expectations are identified. Performance measures may be developed internally or be adopted or adapted from measure sets used in existing databases, which will enable data collection and comparison between or among locations and organizations.
- The new or modified services or processes will be tested and analyzed to determine if the proposed design or modification is an improvement.

DATA USE, ANALYSIS AND UNDERSTANDING VARIATION

A. Criteria used to define performance measures include:

- The measure can identify the events it was intended to identify
- The measure has a documented numerator and denominator statement of description of the population to which the measure is applicable;
- The measure has defined data elements and allowable values;
- The measure can detect changes in performance over time;
- The measure allows for comparison over time within the organization or between the organization and other entities (this may require risk adjustment);
- The data intended for collection are available; and
- Results can be reported in a way that is useful to the organization and other interested stakeholders;

B. Data Collection

- The program will include quality indicator data including patient care data and other relevant data as applicable to the organization.
- Data is collected to monitor the stability and effectiveness of quality of care, treatment and service and patient safety processes, to identify opportunities for improvement, to identify changes that will lead to improvement, and sustained improvement.



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- Data collection is used to identify and prioritize improvement initiatives. In addition, collected data is used to:
 - Establish performance baseline;
 - Describe process performance and stability;
 - Identify areas for more focused data collection; and
 - Sustain improvement.
- Data collection will occur in a manner consistent with any applicable hospital policies and procedures intended to preserve any confidentiality or privilege information established by applicable law. Data collection will include, but may not be limited to the items listed in **Attachment A**.

C. Frequency and Detail of Data Collection

- The Board delegates the frequency and detail of data collection to the Performance Improvement Council. Based on its oversight responsibilities and discretion, the Board, may at any time require changes in either frequency or detail.
- The frequency and detail of data collection will be determined by the CQO or Performance Improvement Council as appropriate.
- The frequency with which data are collected, aggregated and analyzed for additional initiatives will be determined as appropriate to the activity or area being studied.

D. Aggregating and Analyzing Data

- The organization supports excellent data management and assessment, including the use of statistical tools and techniques. Performance Improvement teams and project activities should be data driven and outcome based.
- Data will be compiled in usable formats. Statistical process tools and techniques will be utilized to analyze and display data, as applicable.
- Analysis will be used to identify levels of performance, patterns, trends and variations.
- Data will be analyzed and compared over time either by internal comparison, comparison with similar processes in other organizations and/or comparison to external sources, when available. External sources are as current as possible and include, but may not be limited to:
 - Recent scientific, clinical, and management literature, including Sentinel Event Alert and Alerts for the Institute of Safe Medical Practices, recognized Clinical Practice Guidelines;
 - Well formulated practice guidelines and parameters;
 - Performance measures; and
 - Reference databases.
- Comparative data, as available and appropriate, will be used to determine if there is excessive variability or unacceptable levels of performance.
- Analysis will occur for those topics chosen by the leaders as performance improvement and patient safety priorities, for medical errors and adverse patient events and when an undesirable variation occurs which changes priorities.



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E. Sentinel Events and Intensive Analysis

- When it has been determined that there are substantial undesirable trends or variation in a process or hazardous conditions exist, an intensive analysis is initiated to determine where best to focus changes for improvements. An intensive analysis, is initiated for all sentinel events, as defined in the *Sentinel Event Policy*, when:
 - Levels of performance, patterns, or trends vary substantially and undesirably from those expected; or
 - Performance varies substantially and undesirably from that of other organizations or from recognized standards;
- Intensive analysis involves studying a process to learn in greater detail about how it is performed or how it operates, how it can malfunction, and how errors occur. Certain significant specific clinical events should illicit an intensive analysis includes:
 - Confirmed transfusion reactions;
 - Serious adverse drug events;
 - Significant medication errors;
 - Hazardous conditions;
 - Staffing effectiveness issues;
 - Major discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnosis, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
 - Adverse events or patterns of adverse events during or associated with anesthesia/sedation use.
 - Sentinel events as defined in the *Sentinel Event Policy*.
- Changes are initiated as soon as possible to improve performance, improve patient safety and reduce the risk of sentinel events. For complete definition and process followed for sentinel events, see the *Sentinel Event Policy*.

METHODOLOGIES USED FOR IMPROVEMENT FOR ANALYSIS WORK PROCESSES

- **Additional methodologies utilized for specific project types, include:**
 - *Failure Mode, Effect and Analysis (FMEA)* - A technique used to identify and prevent errors and problems before they occur.
 - *Root Cause Analysis (RCA)* - A technique used to identify underlying root causes and identify subsequent actions to eliminate/minimize process failures.



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ESTABLISHING PRIORITIES AND PRIORITIZATION CRITERIA

- Performance improvement activities will be set by the organization and will:
 - Focus on high-risk, high-volume, or problem prone areas;
 - Consider incidence, prevalence, and severity of problems in those areas;
 - Affect health outcomes, patient safety and quality of care, treatment and services provided; and
 - Consider Strategic Planning Initiative.
- In addition, the following may also be considered in the prioritization process, including when a PI Team should be initiated:
 - Resources required to make improvements or implement recommendations
 - The organization's Mission, and Strategic Planning Initiatives
 - Patient/Customer populations affected
 - Impact on patient safety.
- The organization will take action on identified priorities when established performance levels are not achieved or sustained.
- Organization priorities will be reviewed and approved annually. See **Attachment B (2012 Priorities)**
- Reprioritization may occur in response to changes identified in the internal or external environments.

CHANGE MANAGEMENT, IMPLEMENTING CHANGE AND SUSTAINING IMPROVEMENT

- The organization will use information from data analysis to identify and implement changes and preventative actions and mechanisms that include feedback and learning throughout the organization.
- Actions taken will be aimed at improving performance.
- Performance measures will be established prior to implementing changes in order to determine whether improvements are sustained.
- After implementation of actions, measurement will occur to determine success and track performance to ensure improvement is sustained.
- Appropriate actions will be undertaken when planned improvements are not achieved or sustained.
- In order to sustain improvements that are initiated in the design of new processes or modification of existing processes, the organization will use necessary resources and staff to identify, plan and test changes.
- Education of staff in the changes is a key aspect of this process.

PERFORMANCE IMPROVEMENT PROJECTS AND PROJECT TEAMS

- *Number and Scope of Projects* –
 - The number and scope of distinct improvement projects conducted annually must be proportional to the scope and complexity of the organization's services and operations.
 - The decision to appoint a Chartered Team or to implement an improvement project is made utilizing the criteria described in the *Establishing Priorities and Prioritization Criteria* section of



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this Plan.

- *Documentation of Projects* – PI projects will be documented on an approved format. Documentation will include, but may not be limited to:
 - The reason for conducting the project; and
 - The measurable progress achieved on the project.
- *PI Teams* - These teams are cross functional and interdisciplinary in nature and are generally larger in scope than non-chartered teams. Teams report their findings and recommendations to the Performance Improvement Council for approval.
- *Failure Mode, Effect Analysis (FMEA) Teams* –
 - The organization will proactively seek to identify and reduce risks to the safety of patients through an approach taken to assist in preventing adverse events, as opposed to reacting after adverse events have occurred.
 - FMEAs will be conducted at a frequency and as described in the *Patient Safety Plan*.
- *Root Cause Analysis Teams* - Root Cause Analysis (RCA) teams are initiated in response to a sentinel event, intensive analysis or targeted study. See the *Sentinel Event Policy* for details on RCA teams.

STAFFING/RESOURCE CONSIDERATIONS

- Organization-wide:
 - Work process design should focus individuals on safety and quality.
 - Staffing levels and skill mix should consider and support safety and quality of care, treatment and services.
 - An effective competency program should be fully implemented for individuals working in the hospital and for Medical Staff and AHPs (as defined by *Medical Staff Bylaws* and applicable medical staff policies and procedures).
 - Training, education and communication should support processes for assisting staff, Medical Staff and others to adapt to changes.

PATIENT SAFETY

The leadership of the organization encourages reporting of medical errors, adverse drug events, and potential adverse events as a means to assess and improve and provide a safe environment for patient care. The purpose of the reporting errors is to learn about their causes and enhance processes in order to minimize risk. Staff is encouraged to participate in the detection and reporting of errors, the identification of the system-based causes of errors, and the facilitation of system enhancements to reduce the likelihood of errors. Thus, the focus of the program is performance improvement, not punishment. For details of the Patient Safety Program including oversight and responsibility, see the *Patient Safety Plan*.



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COMMUNICATION

Communication processes will foster performance improvement and patient safety initiatives. Communication will be designed to meet the needs of Internal and external users. Leaders will provide the resources required for communication, based on the needs of patients, the community, physicians, staff, and management. When changes in the environment occur, the organization will communicate those changes effectively. Leaders will evaluate the effectiveness of communication methods periodically.

Leaders of the organization are responsible for discussing issues that affect the organization and the population(s) served, including the following:

- Performance improvement activities;
- Reported safety and quality issues;
- Proposed solutions and their impact on the organization's resources;
- Reports on key quality issues specific to the population(s) served; and
- Input from the population(s) served.

The committee structure supports performance improvement structure of the organization. Activities of these committees are documented in minutes or memos, which, when appropriate, document conclusions (data analysis), recommendations (improvement strategies), action (implementation of improvement activities or committee assignments), and follow-up (effectiveness of actions).

Attachment C

A reporting schedule for issues that affect the organization and the populations(s) served will be maintained by the PI Department. Mechanisms are in place for documenting and communicating performance improvement activities as follows:

- Staff meeting minutes
- Leadership Council minutes
- Performance Improvement Council minutes
- Medical Staff committee minutes
- Board of Director's minutes
- Updates in hospital wide newsletter
- E-mail
- Standardized Sentinel Event Alert Response Form
- Standardized Root Cause Analysis Form

Each department will submit annual summary of Performance Improvement activities for the preceding year to the CQO in January. The CQO will compile an organization-wide annual summary to be submitted to the Board, management, department directors and the medical staff.



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EDUCATION AND TRAINING

- *Staff and Volunteers* –
 - Training on the program and team collaboration is provided during initial orientation and periodically thereafter.
 - In addition, select individuals receive additional training focused on using statistical quality control methods and tools.
- *Medical Staff* - Education is provided via updates provided during medical staff meetings, just-in-time training when participating on a PI or Patient Safety Teams and through information provided in the Medical Staff Orientation Packet.
- *Board Members* – Education on the program is provided during initial orientation and periodically thereafter.

CONFIDENTIALITY

All activities set forth in this Performance Improvement Plan, including any information collected by any medical staff committee, administrative committee, team, or hospital department in order to evaluate the quality of patient care, is to be held in the strictest confidence, and is to be carefully safeguarded against unauthorized disclosure.

PROGRAM EVALUATION

The program and Plan is reviewed, updated, and approved at least annually by the Performance Improvement Council, Medical Executive Committee and the Board of Directors. In addition, leadership self-assessment surveys may be conducted. The review and assessments may consider, but may not be limited to the assessment of:

- How effectively data and information are used throughout the organization
- Effectiveness of planning activities
- Effectiveness of communication methods
- Effectiveness of the management of change and performance improvement
- Effectiveness of those who work in the hospital to promote safety and quality
- The adequacy the allocation of human, information, physical, and financial resources in support of identified performance improvement priorities.

ATTACHMENTS

- *Attachment A – Required Data Collection Elements*
- *Attachment B – 2012 Performance Improvement & Patient Safety Priorities*
- *Attachment C – Committee Organizational Chart*



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ADDITIONAL SUPPORTING DOCUMENTS

- *Patient Safety Plan*
- *Sentinel Event Policy*
- *Medical Staff Bylaws, Rules/Regulations and Related Medical Staff Performance Improvement Policies, including Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation*

REFERENCES:

CMS
The Joint Commission Standards



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APPROVAL

Governing Body Signature

Date

Chief of Staff Signature

Date

Chief Executive Officer Signature

Date

Chief Quality Officer Signature

Date

ATTACHMENT A REQUIRED DATA COLLECTION ELEMENTS

Priorities Identified by the Organization's Leaders

2. Core Measures
3. Measures of Success Identified Through Periodic Performance Review Process
4. Measures of Success Identified Through and By JC and CMS Survey Findings
5. National Patient Safety Goals as required by Joint Commission, including, **but not be limited to:**
 - Timeliness of Reporting Critical Tests and Results
 - Use of Do Not Use Abbreviations, Acronyms and Symbols
 - Anticoagulation Therapy
 - Hand Hygiene
 - Sentinel Event Related Infections
 - Multi-drug Resistant Organisms Infections
 - Central Line Blood Stream Infections
 - Patient Falls
 - Rapid Response Team
 - Universal Protocol
6. Safety and Quality Cultural Assessment, including staff perceptions of risk, willingness to report adverse events and suggestions for improving patient safety
7. Patient/Family Perceptions of the Safety and Quality of Care, Treatment and Services
8. Medication Management, including Significant Adverse Drug Reactions and Significant Medication Errors
9. Use of Blood and Blood Components
10. All Confirmed Transfusion Reactions
11. Restraint and Seclusion
12. Operative and Other Invasive or Non Invasive procedure That Place Patients at Risk of Disability or Death
13. Significant Discrepancies In Preop and Postop Diagnosis, including Pathologic diagnoses
14. Adverse Events Related to Using Moderate Sedation, Deep Sedation or Anesthesia
15. Outcomes Related to Resuscitation
16. Contract Services Quality and Safety Review
17. Patient Flow and Throughput
18. Use of Autopsy Criteria
19. Mortality Review
20. Concurrent Chart Review
21. Use of Verbal/Telephone Orders
22. Monitoring Content of History and Physicals
23. Medical Record Delinquency Rate

ATTACHMENT B

2013 Performance Improvement & Patient Safety Priorities

How Selected: Priorities selected will-

- Focus on high-risk, high-volume, or problem prone areas;
- Consider incidence, prevalence, and severity of problems in those areas;
- Affect health outcomes, patient safety and quality of care, treatment and services provided; and
- Consider Strategic Planning Initiatives.

Priorities:

2013 Priorities	Measurement/Metric	Benchmark*										
National Patient Safety Goals will be fully Implemented as evidenced by: <ul style="list-style-type: none">Current policies/procedures in place for each NPSGNPSG Scorecard will track overall compliance with Implementation of each goal. Significant findings will be entered on the Hospital-wide Dashboard.	Number of significant findings as defined on the Hospital wide Dashboard	Established for Individual NPSGs on the Hospital-wide Dashboard										
Patient Satisfaction will meet or exceed benchmarks established in the 2012 Strategic Plan	Defined per DMR	<table><tr><th></th><th>RAW SCORE</th></tr><tr><td>Inpatient</td><td>>85%</td></tr><tr><td>Outpatient</td><td>>85%</td></tr><tr><td>ED</td><td>>80%</td></tr><tr><td>Amb/Surg</td><td>>85%</td></tr></table>		RAW SCORE	Inpatient	>85%	Outpatient	>85%	ED	>80%	Amb/Surg	>85%
	RAW SCORE											
Inpatient	>85%											
Outpatient	>85%											
ED	>80%											
Amb/Surg	>85%											
Core Measures will meet or exceed established benchmarks <ul style="list-style-type: none">AMICHFPNASCIPOP AMIOP SCIPED	Defined per CMS	Defined per COMET										
Overall Employee Satisfaction will meet or exceed established threshold	Defined per Edge Healthcare Research	≥85%										
Overall Willingness to Report Potential/Actual Errors as indicated on the 2011 Culture of Safety Survey	Defined per AHRQ Culture of Safety Survey	<table><tr><th></th><th>RAW SCORE</th></tr><tr><td>Willingness to report if mistake made, <u>but caught before reaching patient</u></td><td>≥85 % of staff surveyed will indicate "Always"</td></tr><tr><td>Willingness to report if mistake made, <u>but no potential harm to patient</u></td><td>≥85 % of staff surveyed will indicate "Always"</td></tr><tr><td>Willingness to report if mistake that <u>could harm the patient</u>, but does not</td><td>≥85 % of staff surveyed will indicate "Always"</td></tr></table>		RAW SCORE	Willingness to report if mistake made, <u>but caught before reaching patient</u>	≥85 % of staff surveyed will indicate "Always"	Willingness to report if mistake made, <u>but no potential harm to patient</u>	≥85 % of staff surveyed will indicate "Always"	Willingness to report if mistake that <u>could harm the patient</u> , but does not	≥85 % of staff surveyed will indicate "Always"		
	RAW SCORE											
Willingness to report if mistake made, <u>but caught before reaching patient</u>	≥85 % of staff surveyed will indicate "Always"											
Willingness to report if mistake made, <u>but no potential harm to patient</u>	≥85 % of staff surveyed will indicate "Always"											
Willingness to report if mistake that <u>could harm the patient</u> , but does not	≥85 % of staff surveyed will indicate "Always"											

* Benchmark sources maybe further defined on organization-wide or Individual report scorecards/dashboards.

Adjusting Priorities:

Priorities may be adjusted throughout the course of the year based on response to unusual or urgent events.

Tab 15

Attachment C
Contribution to the Orderly Development of Health Care – 5

Utilization Review Plan



DEPARTMENT: QRM	PLAN DESCRIPTION: Utilization Review and Case Management Plan
PAGE: 1 of 10	APPROVED: 7/2012
EFFECTIVE DATE: July 2012	REFERENCE NUMBER: ADM.HP.011
APPROVED: Tim McGill, CEO	RETIRED:

1. **Introduction:** The River Park Hospital Utilization Review/Case Management Plan contains reference to case management and utilization review. The case management component reflects the responsibility for the program to effectively manage resource utilization. Utilization review refers to the actual process of reviewing patient care. This plan has been developed by the Case Management department, and approved by the Medical Executive Committee and the Governing Board.
2. **Authority:** The Governing Board, Administration, and the Medical Staff have delineated the responsibility and authority to the case management function to monitor appropriate utilization of hospital services and resources.
3. **Purpose:** The purpose of the Utilization Review/Case Management Plan is to assess and improve the delivery of care to all patients, regardless of payment source in an efficient and effective manner. The plan describes methods for conducting utilization reviews of the appropriateness of admissions, continued stay, supportive services and for providing discharge planning.
4. **Organization:**
 - A. The UR/CM reporting will be via the Utilization Review Committee.
 - B. The Utilization Review/Case Management function will report quarterly or more often as needed. Specific UR data related to the service of the physician will be included in the physician quality profile.
5. **Responsibilities:**

The responsibilities of the committee may be carried out by the whole committee, a subcommittee, or by delegated agents, such as the Director of Case Management, Chief Financial Officer, Patient Access Director, Chief Quality Officer, Risk Manager, and/or Case Managers. The responsibilities include:

 - A. To assure the development, maintenance, and execution of an effective utilization review plan, to review and revise annually as necessary.
 - B. To collaborate in monitoring and analyzing the review activities of the Case Managers, the CQO, the Director of Case Management and the Physician Advisor or designee.
 - C. To monitor the appropriate utilization of beds and support services through concurrent and retrospective reviews of the necessity for inpatient admissions, appropriate duration of stays, and timely and appropriate use of diagnostic and therapeutic services.



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1. The CQO, Director of Case Management, Case Managers, and/or the committee shall conduct the reviews falling under this plan concurrently and or retrospectively.
2. Third Party Commercial Insurers who request access to the medical records for review purposes on discharge patients must request access through HIM. If the patient is in-house, reviewers must work in conjunction with CM on those patients.
- B. Information needed to perform UR – the following information will be included in the medical record in order to provide the function of UR:
 1. Patient identification
 2. Attending physician
 3. Date of Admission
 4. Plan of care
 5. Dates of operative procedures
 6. Justification for emergency admission
 7. Reason for continued stay, if necessary
- C. Selection of patients to be reviewed concurrently:
 1. All inpatients and outpatients are subject to review regardless of payer source
 2. Any patient where an identified utilization management concern is brought to the attention of case management from any source
 3. Transfers
 4. One day inpatient admissions
 5. Observation admissions
 6. Patients identified by Peer Review organizations and individual insurance companies.
 7. 31-Day readmissions
 8. Mortality
 9. Condition Code 44
- D. Pre-Admission Review:
 1. In accordance with CMS regulations and other third party requirements, pre-admission certification is carried out through the Admissions Office prior to or at the time of admission.
 2. If the patient's case does not appear to meet admission criteria, the case is referred to a case manager who will review the case for medical necessity. If additional information is needed the CM will contact the attending physician. If the physician agrees the status of the patient may be changed, if appropriate. If the physician does not agree the physician may be assigned an "opportunity day" for each day of admission that the patient does not meet medical necessity as listed by Interqual Criteria.
- E. Admission Review



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1. Notification of all admissions by the admission office will be made to the CM's via computerized clinical information systems. The CM's will also print Copies of the medical record face sheet on each new admission. The face sheet copy will include the patient's name, room number, physician, admission date, third party payer, admission diagnosis, and precertification phone number is required.
2. A case Manager will review each admission. This review will consist of screening admissions utilizing the latest Intensity of Service/Severity of Illness criteria mandated by the Peer Review Organization with modifications as specified by the Agency for health Care Administration using Interqual criteria.
3. A second level of review occurs if a questionable case is identified which cannot be approved by the Case Manager. The Case Manager will contact the attending physician, physician advisor or designee for more information
4. Effective July 1, 2007 the revised "Important Message from Medicare" is made available to all acute in-patients and all rehab in-patients. The first copy of the notice is given to the patient upon admission by Registration/Admissions followed by a second copy no more than 48 hours or less than 4 hours prior to discharge, given by the Case Manager.
This time frame allows the patient to file a formal appeal with the QIO for an expedited review of the discharge decision.
5. Notification of denial may be given to the patient in the form of the Hospital Issued Notice of Non coverage for Admission, with copies to the Attending Physician, the Case Management Department, the Business Office, and the Peer Review Organization. This notice includes a statement of the patient's right to appeal and the method to file such an appeal. The Case Manager will complete the letter of denial after the physician determines patient stay is not justified. The letter shall contain sufficient reconsideration of the determination. The right of the reconsideration shall exist even though the patient has left the hospital before filing the reconsideration request. The notice shall specify timeframes for reconsideration and the procedures for requesting reconsideration.
6. At the time of admission, the Case Manager will initiate a Case Management Review. The Case Manager will assign the first continued stay review date. All admission and subsequent continued stay reviews will be documented on this record. At discharge, the review documents will be filed in the Case Management department Office and maintained for two (2) years.
7. The U.R. Committee or the Director of Case Management may identify opportunities for focus reviews. Appropriate supporting data shall be obtained



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through retrospective monitoring. If such concerns are identified, methods for correction or prevention will be considered and recommendations forwarded to the appropriate hospital committee.

8. When there is a delay in a support service, verbal contact with the involved department is made to expedite appropriate utilization.

F. Continued Stay/Concurrent Review

1. Once admission is approved, continued stay review will be performed by the Case Managers as deemed necessary by Case Managers when problems or trends are identified that warrant a more focused review, or as requested or required by regulatory agencies and commercial insurance.
2. The CMS Geometric Mean Length of Stay by MS DRG as published by the Federal Register will be used as a guideline for length of stay comparisons. This may vary depending on the age/disability of the group of the patient.
3. Patient charts shall be reviewed by the Case Managers for the level of service provided, medical necessity, and the need for continued hospitalization.
4. If it becomes apparent that further inpatient hospitalization is not justified, the Case Manager will contact the attending physician. If the physician agrees, the patient will be discharged. If there are undocumented factors which result in the criteria not being met, the Attending Physician concurs that further hospitalization is not justified, but the patient objects to the discharge, the Case Manager will collaborate with the business office and will issue a Hospital Notice of Non-Coverage Continued Stay Denial Letter to the patient or his representative. This letter will be issued only after consultation with the attending physician, Administration, the Business Office, the Case Management Department, and Utilization Review Committee members on the same day the decision is made.
5. If discharge screens are met but the attending physician does not agree to discharge the patient, the case may be referred to a Physician Advisor or designee for a second opinion. A notice of non-coverage will not be issued without the agreement of all parties involved.
6. River Park Hospital will follow procedures described in Medicare and Medicaid rules for patients served with notices of non-coverage.

G. Review of the Individual Days of Care

1. Utilization related concerns, i.e., identification of underutilization of services, delays in care, inefficient scheduling of resources, and appropriateness of services, are identified through both the referral of the Case Managers pattern analysis, and the Performance Improvement Process.



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2. During continued stay review process, the Case Managers will also be monitoring possible avoidable days, i.e., delays/unavailability of hospital services, delays in test results, social or placement problems, missed orders, delays attributed to patients or physicians convenience, that lead to unnecessary days of hospitalization. This information will be documented by Case Management. Possible avoidable days will be analyzed by the Director of Case Management for patterns or trends. This information will be reported as part of the Utilization Review/Case Management Report to the Utilization Review Committee, Medical Executive Committee (MEC), Board of Trustees (BOT), and other meetings as deemed appropriate.
3. Underutilization of services will be screened by the Case Managers during the concurrent process.
 - (a.) Patient records will be screened for patient care services that are not ordered and/or provided for. Records will also be reviewed for appropriate utilization of ICU and Telemetry beds, as well as following up on abnormal test results. The attending physician will be contacted regarding a concern.
 - (b.) Readmissions within 30 days will be reviewed for possible premature discharge on the first admission. These patient records will be reviewed for meeting discharge screens. Any cases not meeting discharge screens will be forwarded to the Physician Advisor or designee through the quality screen review process. As patterns or trends are identified with a particular practitioner the information will be reported to the appropriate committee structure.
 - (c.) Concurrently, the Case Managers review records to ascertain that discharge screens are met prior to the patient's discharge. If discharge screens are not met and the discharge order is written, the Case Manager will contact the attending physician. The Case Managers will compare data to peer norms to identify any patterns of under/over utilization per MSDRG's by physician.
4. Appropriateness of Services-at the UR work sessions, appropriateness review of designated high volume, high cost, high risk services in areas such as Radiology, Pharmacy, Respiratory, and Laboratory will be reported as trends are identified.

H. Data Analysis and Reporting

Data shall be gathered for admission certification and continued stay reviews. Day outliers and cost outliers will be analyzed and reported to the U.R. Committee. The summary report of Case Management and UR activities will be presented to The



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Medical Executive Committee as indicated, as well as other hospital department and Medical Staff meetings as appropriate.

I. Medical Care Evaluation Studies

The HIM Committee within the medical record function shall assist in selecting and conducting patient care review studies within the hospital. The results of the audits shall be documented and recommendations for corrective action to improve identified areas will be made to the appropriate medical staff committee or hospital department. Sources of data used to conduct these studies include the medical record, data profiles from hospital information systems, and cooperative endeavors with QIO's, FI and other appropriate agencies.

10. CMS Quality Reviews/Notice of Non Coverage

1. When the hospital QIO Contact receives notice of a possible quality concern regarding patient care the appropriate physician will be notified. Exchange of information regarding the issue will be between the hospital, QIO and the Fiscal Intermediary, when appropriate.
2. The hospital shall furnish to the QIO and the FI the written notice of any adverse initial determination made by the hospital with regard to services to a beneficiary. The written notice will be in the form of the Hospital UR Notice of Non-Coverage advising the patient that benefits will cease after a specific date.

11. Committee Reports and Records

The Director of Case Management will be responsible for maintaining individual and aggregated patient data with respect to reviews. The Director of Case Management will be responsible for distributing reports to appropriate individuals and committees. All Utilization Review findings will be confidential.

12. Linking Results to Medical Evaluation

When opportunities are identified to improve the utilization and quality care of patients, recommendation for action shall be the responsibility of the Medical Staff and shall be documented as part of the continuing education function.

13. Relationship to Third Party Payers

The hospital shall be responsible to see that individuals involved in the Utilization Review function are made aware of the mechanisms of receiving and presenting claims to third parties,



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including the Fiscal Intermediary, the basis on which payment is allowed by the FI, the conditions under which the FI denies claims and the claims appeal data about a case shall be open to review by fiscal intermediaries, state agencies, and Peer Review Organizations. Information and data concerning the peer review process shall be protected and considered confidential.

14. Hospital Administration

The hospital administration shall provide assistance to assure proper functioning of the Case Management Program and the information is appropriately assembled, secretarial assistance and meeting space is provided. Administration shall be responsible for considering and acting upon decisions and recommendation stemming from the Utilization Review Committee with respect to hospital policy, procedures and staffing. The Case Management Department will report to the Chief Financial Officer.

15. Discharge Planning

The process of discharge planning begins prior to or at the time of admission for all patients. The Case Manager screens all patients to assess their potential post hospitalization needs. The CM works with the attending physician, the patient, and the patient's family to insure continuity of care post discharge. River Park Hospital maintains an open referral system so that the initiation of discharge planning is not delayed until the physician writes the discharge order. Input regarding the need for continued post hospital care is sought from nursing as well as ancillary departments. The CM assess discharge planning needs at the time of services and assess if nursing home, home health care, hospice or transportation is needed. Discharge planning activities include provisions for, or referral to, services required to improve or maintain health status post discharge.

The open referral system provides for access from any source for consultation with the Case Manager for referral to additional resources. These include but are not limited to, financial assistance, counseling, and guardianship programs.

16. Interface With Quality Improvement, Risk Management And/Or Medical Staff

Utilization review is one of the components of the Performance Improvement Program. During the course of concurrent or retrospective review, the Case Managers will screen patient records for quality and risk concerns, including specific sentinel events as designated by the Chief Quality Officer or Risk Manager.

If any concerns are identified through Utilization Review they will be documented and referred to Quality Services. Utilization Review functions and the Performance Improvement



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functions will be integrated as follows:

1. The appropriate Medical Staff or hospital committee will forward any quality concerns to the CQO or the Risk Manager for review.
2. If a potential quality issue is identified during the course of utilization review and is considered to be in immediate need of correction the Physician Advisor or designee will review the record and contact the appropriate physician or hospital department manager for discussion of the concern. If the attending physician or Department Manager is unwilling to correct the problem, the Chairperson of the attending physician's department or Administration and the CQO or Risk Manager will also be notified.
3. If a potential quality issue is identified and correction has occurred, the case will be referred to the CQO for referral to the appropriate Medical Staff or hospital committee.

17. Revision and Review

The Utilization Review Plan will be reviewed annually by the Director of Case Management and revised as necessary. The Medical Executive Committee and Board of Trustees will approve any revision of the plan.

PROCEDURE:

REFERENCES:



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APPROVAL

Governing Body Signature

Date

Chief of Staff Signature

Date

Chief Executive Officer Signature

Date

Director of Case Management Signature

Date

Tab 16

Attachment C
Contribution to the Orderly Development of Health Care – 5

Patient Bill of Rights



River Park Hospital

In partnership with Saint Thomas Health

PATIENT RIGHTS/RESPONSIBILITIES

Patient Rights

The basic rights of all patients at River Park Hospital:

- A. The patient has the right to a reasonable response to his/her treatment needs and requests for service. The care provided by the hospital must be within the organization's stated mission and capacity, as well as applicable law and regulation. When medically permissible, a patient may be transferred to another facility, should the hospital be unable to meet his/her needs. The transfer shall occur only after the patient has received complete information regarding the necessity for and alternative options to such a transfer. The receiving facility must approve any patient transfer.
- B. Each patient, regardless of race, sex, religion, disability, creed, age, or source of payment shall have the right to receive respectful and considerate care. The hospital recognizes that each patient has individual psychosocial, spiritual and cultural needs and values, which may affect his/her response to the care given. Every consideration is given to accommodating these needs. The patient has the right to express spiritual beliefs and cultural practices, provided such activities do not harm others or interfere with the patient's planned course of treatment.
- C. The relationship between the patient and his/her physician represents a unique partnership. It is recognized that the patient has a right to express preferences and to participate in decisions pertaining to the provision of health care services within the hospital. If the patient is a neonate, child, or adolescent, the parent(s) or legal guardian(s) shall have the right to participate in the decision-making process on behalf of the patient.
- D. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of such refusal. Should the refusal of treatment by the patient or his/her legally authorized representative prevent the provision of appropriate care in accordance with ethical and professional standards, the relationship with the patient may be terminated by the physician, upon reasonable notice.
- E. It is recognized that each patient has the right to formulate advance directives such as the appointment of a health care surrogate, durable power of attorney for health care, or living will. Upon admission, the patient or his/her legally designated representative is asked whether an advance directive exists. Patients without advance directives are informed of their rights to make advance health care decisions and are offered printed informational materials detailing their options.
- F. The patient has the right to know by name and specialty the physician responsible for his/her care, as well as the name and function of any individual providing services to him/her. The patient has the right to receive from his/her physician information necessary to give informed consent prior to the initiation of any procedure and/or treatment.
- G. The hospital's Clinical Ethics Committee shall be the forum for the consideration of ethical issues that arise in the care of the patient.
- H. Each patient has the right to be informed of any experimental, research, or educational activities that may affect his/her care or treatment. The patient has the right to refuse to participate in any such clinical research studies.
- I. Each patient has the right to every consideration of privacy and respectfulness concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. Those not directly involved in the delivery of care must have permission of the patient to be present. Patient examinations and treatments are conducted in surroundings designed to give reasonable visual and auditory privacy. Patients may request a transfer to a different room if another patient or visitor in the room is unreasonably disturbing him/her and another room equally suitable is available.
- J. The patient has the right to privacy and confidentiality of all communications and records pertaining to his/her treatment, except as otherwise provided by law or third party payment contract. The patient or his/her legally designated representative has access to the information contained in the patient's medical record, within the limits of this law.
- K. The neonate, child, and adolescent/minor patients, and their parents and /or legal guardians shall be afforded the same rights as the adult patients. Minor patients have the right to be attended by a parent, or other responsible adult designated by the parent or legal guardian, while in the Emergency Dept. and/or PACU.

- L. Hospital staff members are aware of the unique and special needs of the patient at the end of life. Respect for the values, belief systems, and philosophies of the patient and family members is demonstrated through the provision of support for these individuals' psychological, social, emotional, and spiritual needs, especially as related to the coping/grieving process.
- M. Each patient has the right to expect reasonable continuity of care and shall be informed by his/her physician or delegate of any continuing health care requirements following discharge.
- N. Each patient, regardless of source of payment, has the right to receive an itemized bill and explanation of charges for services rendered in the hospital.
- O. Each patient has the right to be informed of the hospital's rules and regulations applicable to his/her conduct as a patient.
- P. Each patient has the right to obtain information as to any relationships among individuals treating him/her and between the hospital and other health care and educational institutions insofar as his/her care is concerned.
- Q. The patient has the right to leave the hospital against the advice of his/her physician to the extent permitted by law. Neither the hospital nor the physician shall be responsible for any harm resulting from the patient leaving "against medical advice."
- R. The patient who does not speak English shall have access to an interpreter. A TDD and amplified telephones are available for the hearing impaired patient and or visitor. The patient shall have access to people outside the hospital by means of visitors as well as verbal and written communication.
- S. Each patient has the right to expect reasonable safety insofar as the hospital practices and environment are concerned.
- T. Hospital policies on the withholding of resuscitative services from patients and the foregoing or withdrawing of life-sustaining treatment have been developed in consultation with the medical, nursing, and administrative staffs.
- U. Upon admission, the Medicare patient will receive the Medicare "Bill of Rights" informational sheet which explains and educates the Medicare patient of his/her rights.
- V. The patient has the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient by blood or marriage.

Patient Responsibilities

Patients are responsible for providing River Park Hospital and their practitioners with complete and accurate information regarding present and past illnesses and operations, hospitalizations, medications, and other health-related items, including any unanticipated changes in their condition.

- A. Each patient has the responsibility to provide, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her condition to the responsible practitioner. A patient is responsible for making it known whether he/she clearly comprehends a contemplated course of action and what expectations should be met.
- B. Each patient is responsible for following the treatment plan recommended by the practitioner primarily responsible for his/her care. This may include following the instruction of nurses and allied health personnel as they carry out the coordinated plan of care and implement the responsible practitioner's orders, and when he/she is unable to do so for any reason, for notifying the responsible practitioner or the hospital.
- C. The patient shall be held responsible for any occurrences resulting from refusal of treatment or failure to follow the practitioner's instructions.
- D. The patient is responsible for assuring that the financial obligation of his/her health care services are fulfilled as promptly as possible.
- E. The patient is responsible for being considerate of the rights of other patients and hospital personnel. The patient must assure that his/her visitors are considerate of others, and that unnecessary noise and unreasonable behavior do not annoy other patients. The patient is responsible for being respectful of the property of other persons and of the hospital.
- F. Once the patient leaves the hospital, he/she is responsible for maintaining the treatment recommended by his/her physician. The physician should be advised if the patient anticipates difficulty in following the prescribed treatment plan.
- G. A parent, legal guardian or their designee must be in attendance or in a designated waiting area, while a minor is a patient.
- H. The patient is responsible for informing the hospital as soon as possible if it is believed that any of his/her rights have or may be violated. The parent or legal guardian of the neonate, child, or adolescent patient is responsible for informing the hospital as soon as possible if it is believed that the minor's rights have been violated.
- I. The patient is responsible for asking the doctor or nurses what to expect regarding pain and pain management,

discussing pain relief options with doctors or nurses, working with the doctor or nurses to develop a pain management plan, asking for pain relief when pain first begins, helping the doctor or nurse measure his/her pain, and notifying the doctor or nurse when the pain is not relieved.

PATIENT RIGHTS ADDENDUM

The Patient has the right to:

- *Be informed/participate in decisions regarding care;
- *Designate a decision maker;
- *Have access to protective services;
- *Participate in the development and implementation of the care plan;
- *Have family members and the patient's physician notified promptly of the patient's admission;
- *Receive care in a safe setting;
- *Be free from all forms of abuse or harassment;
- *Have access to information in the patient's record within a reasonable time frame;
- *Be free from restraint or seclusion of any form that is not medically necessary or is used as a means of coercion, discipline, convenience, or retaliation by staff;
- *Receive information about pain and pain relief measures, a concerned staff committed to pain prevention, health professionals who respond quickly to reports of pain, and state of the art pain management;

Centers for Medicare and Medicaid Services
Atlanta Federal Center
61 Forsyth St. SW Ste 4T20
Atlanta, GA 30303-8909
Phone (404)562-7500
Fax (404)562-7162

Tennessee Dept. of Health
Healthcare Facilities Complaint Hotline
1-877-287-0010

The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Toll-free 1-800-994-6610
email: complaint@jointcommission.org

Tab 17

Attachment C
Contribution to the Orderly Development of Health Care - 7.(b)

The Joint Commission Documentation



Accreditation Quality Report

- > Summary of Accreditation Quality Information
- > Accredited Programs
- > Accreditation National Patient Safety Goals
- > Sites and Services
- > Accreditation History
- > Download Accreditation PDF Report
- > Download Accreditation PDF Report - Include Quarterly Data
- > Accreditation Quality Report User Guide

Quality Report

Summary of Accreditation Quality Information



River Park Hospital
 Org ID: 7866
 1559 Sparta Road
 McMinnville, TN 37110
 (931)815-4000
www.riverparkhospital.com

Accreditation Programs

[Hospital](#)

Accreditation Decision

[Accredited](#)

Effective Date

6/1/2013

Last Full Survey Date

5/31/2013

Last On-Site Survey Date

5/31/2013

Accreditation programs recognized by the Centers for Medicare and Medicaid Services (CMS)
 Hospital

- Top -

Symbol Key

- This organization achieved the best possible results
- This organization's performance is above the target range/value.
- This organization's performance is similar to the target range/value.
- This organization's performance is below the target range/value.
- This measure is not applicable for this organization.
- Not displayed

Footnote Key

1. The measure or measure set was not reported.
2. The measure set does not have an overall result.
3. The number is not enough for comparison purposes.
4. The measure meets the Privacy Disclosure Threshold rule.

Reporting Period:
 Oct 2012 -
 Sep 2013

National Patient Safety Goals and National Quality Improvement Goals

Compared to other Joint Commission Accredited Organizations

Nationwide

Statewide

Hospital

2013 National Patient Safety Goals [See Detail](#)



[National Quality Improvement Goals:](#)

Heart Attack Care

[See Detail](#)



Heart Failure Care

[See Detail](#)



Pneumonia Care

[See Detail](#)



Surgical Care Improvement Project (SCIP)

SCIP - Cardiac

[See Detail](#)

SCIP - Infection Prevention For All Reported Procedures:

[See Detail](#)



• Colon/Large Intestine Surgery

[See Detail](#)



• Hip Joint Replacement

[See Detail](#)



• Hysterectomy

[See Detail](#)



5. The organization scored above 90% but was below most other organizations.
6. The measure results are not statistically valid.
7. The measure results are based on a sample of patients.
8. The number of months with measure data is below the reporting requirement.
9. The measure results are temporarily suppressed pending resubmission of updated data.
10. Test Measure: a measure being evaluated for reliability of the individual data elements or awaiting National Quality Forum Endorsement.

- Knee Replacement

[See Detail](#)

SCIP – Venous Thromboembolism (VTE)

[See Detail](#)The Joint Commission only reports measures endorsed by the [National Quality Forum](#).

* State results are not calculated for the National Patient Safety Goals.

[- Top -](#)**Sites and Services***** Primary Location**

An organization may provide services not listed here. For more information refer to the [Quality Report User Guide](#).

Locations of Care

Middle Tennessee Surgical Center
145 Health Way
Mc Minnville, TN 37110

Available Services**Services:**

- Administration of High Risk Medications (Outpatient)
- Ambulatory Surgery Center (Outpatient)
- Anesthesia (Outpatient)
- Perform Invasive Procedure (Outpatient)

River Park Hospital *
1559 Sparta Road
Mc Minnville, TN 37110

Services:

- CT Scanner (Imaging/Diagnostic Services)
- EEG/EKG/EMG Lab (Imaging/Diagnostic Services)
- Gastroenterology (Surgical Services)
- GI or Endoscopy Lab (Imaging/Diagnostic Services)
- Gynecological Surgery (Surgical Services)
- Gynecology (Inpatient)
- Labor & Delivery (Inpatient)
- Magnetic Resonance Imaging (Imaging/Diagnostic Services)
- Medical /Surgical Unit (Inpatient)
- Medical ICU (Intensive Care Unit)
- Normal Newborn Nursery (Inpatient)
- Nuclear Medicine (Imaging/Diagnostic Services)
- Ophthalmology (Surgical Services)
- Orthopedic Surgery (Surgical Services)
- Post Anesthesia Care Unit (PACU) (Inpatient)
- Rehabilitation Unit (Inpatient, 24-hour Acute Care/Crisis Stabilization)
- Sleep Laboratory (Sleep Laboratory)
- Teleradiology (Imaging/Diagnostic Services)
- Ultrasound (Imaging/Diagnostic Services)
- Urology (Surgical Services)

[- Top -](#)

The Joint Commission obtains information about accredited/certified organizations not only through direct observations by its employees [...Read more.](#)

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Tab 18

Attachment C
Contribution to the Orderly Development of Health Care - 7.(c)

Hospital License

Board for Licensing Health Care Facilities



State of Tennessee

DEPARTMENT OF HEALTH

00000000120

No. of Beds 0125

This is to certify, that a license is hereby granted by the State Department of Health to

to conduct and maintain a

RIVER PARK HOSPITAL, LLC

Hospital

RIVER PARK HOSPITAL

Located at

1559 SPARTA STREET, MC MINNVILLE

County of

WARREN

, Tennessee.

This license shall expire APRIL 08, 2015, *and is subject*

to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.

In Witness Whereof, we have hereunto set our hand and seal of the State this 8TH *day of* APRIL, 2014.

In the Distinct Category (es) of: GENERAL HOSPITAL
PEDIATRIC BASIC HOSPITAL



By

David J. Davis, MPH

DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By

John D. Davis

COMMISSIONER

000332

Attachment D

**Copy of Published Public Notice
Letter of Intent**

Tab 19

Attachment D

Copy of Published Public Notice

Attachment D

Letter of Intent

PLACEHOLDER PUBLIC NOTICE

Tab 20



State of Tennessee
Health Services and Development Agency

Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

www.tn.gov/hsda

Phone: 615-741-2364

Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Southern Standard which is a newspaper
of general circulation in Warren, Tennessee, on or before July 9, 2014
(County) (Month / day) (Year)
for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

River Park Hospital, LLC an existing Hospital
(Name of Applicant) (Facility Type-Existing)
owned by: Capella Healthcare, Inc. with an ownership type of For-Profit Corporation
and to be managed by: River Park Hospital intends to file an application for a Certificate of Need
for [PROJECT DESCRIPTION BEGINS HERE]: the initiation of geriatric psychiatric services at River Park Hospital. The
project proposes the conversion of ten (10) of the hospital's existing licensed general medical/surgical beds to
geriatric psychiatric beds. Renovation of approximately 5,066 square feet of existing space on the third floor
of River Park Hospital will be required. No new beds or major medical equipment are being requested for the
project. The total cost of the project is estimated to be \$1,199,250.

The anticipated date of filing the application is: July 14, 2014

The contact person for this project is Joseph Mazzo Chief Operating Officer
(Contact Name) (Title)

who may be reached at: River Park Hospital 1559 Sparta Street
(Company Name) (Address)
McMinnville TN 37110 931 / 815-4203
(City) (State) (Zip Code) (Area Code / Phone Number)

Joseph Mazzo 7/3/14 Joseph.Mazzo@cappellahealth.com
(Signature) (Date) (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

HF51 (Revised 01/09/2013 - all forms prior to this date are obsolete)

ence South 17 deg. 46 in. West, 219 feet with the st margin of the Green fill and Centertown Road the beginning, and containing 2.0 acres more less, as per the survey of arl W. Smith, 4-4-81.

Being the same property conveyed to Stephanie A. ain by Warranty Deed om Paul Holder, Steven fill and David Miller dated March 6, 1998 and rded in WD Book 8, Page 950, Register's fice of Warren County, ennessee.

cluded in this conveyance a 1998 Fleetwood obile home, Serial NFLW27AB17578SR12. This is improved property own as 5058 West Green ill Road, McMinnville,

that I, RYAN J. MOORE, Successor Trustee, pursuant to the power, duty and authority vested in and conferred upon me, by the Deed of Trust, will on August 8, 2014, at 10:00 a.m. at the front door of the Warren County Courthouse in McMinnville, Tennessee, offer for sale to the highest bidder for cash, and free from all legal, equitable and statutory rights of redemption, exemptions of homestead, rights by virtue of marriage, and all other exemptions of every kind, all of which have been waived in the Deed of Trust, certain real property located in the 1st Civil District of Warren County, Tennessee, described as follows:

Tract No. 1: Lots 88, 89, 90,

Apartment! Apartment!

1, 2 & 3 bedroom units
All utilities included
Satellite TV Included
Weekly & Monthly Payment Plans

Call 474-2082

Creekstone Apartments

4104

McMinnville Arms Apartments

Accepting applications on 1-2-3 bedroom apartments for families, individuals, elderly and handicap persons. Rent is based on 30% of gross yearly income, less eligible allowances. HUD income limits and all eligibility screening requirements apply for admission. Water-Sewer-Trash furnished, pets, pet fees and pet policy apply. Please apply at the rental office for an application during normal business hours posted at office located at 932 Old Smithville Rd., McMinnville, TN 37110 or contact 931-473-8353 for further information.

McMinnville Arms Apartments does not discriminate against any person because of race, color, religion, sex, handicap, familial status, or national origin



Equal Housing Opportunity



7573

J&N MINI WAREHOUSES

2429 NASHVILLE HWY. • McMINNVILLE, TN 37110

SPECIAL

5x10 Warehouse \$20 Per Month

PHONE 668-9524

114956

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that River Park Hospital, LLC, an existing Hospital, owned by: Capella Healthcare, Inc. with an ownership type of For-Profit Corporation and to be managed by: River Park Hospital, intends to file an application for a Certificate of Need for: the initiation of geriatric psychiatric services at River Park Hospital. The project proposes the conversion of ten (10) of the hospital's existing licensed general medical/surgical beds to geriatric psychiatric beds. Renovation of approximately 5,066 square feet of existing space on the third floor of River Park Hospital will be required. No new beds or major medical equipment are being requested for the project. The total cost of the project is estimated to be \$1,199,250.

The anticipated date of filing the application is July 14, 2014. The contact person for this project is Joseph Mazzo, Chief Operating Officer, who may be reached at River Park Hospital, 1559 Sparta Street, McMinnville, TN, 37110, 931-815-4203.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

7622



State of Tennessee

Health Services and Development Agency

Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243

www.tn.gov/hsda

Phone: 615-741-2364

Fax: 615-741-9884

August 1, 2014

Joseph Mazzo, COO
River Park Hospital
1559 Sparta Street
McMinnville, TN 37110

RE: Certificate of Need Application for River Park Hospital, LLC - CN1407-030

Dear Mr. Mazzo:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need for the initiation of inpatient geriatric psychiatric services and the conversion of ten (10) medical/surgical beds to geriatric psychiatric beds. The estimated project cost is \$1,199,250.00.

Please be advised that your application is now considered to be complete by this office. Your application is being forwarded to the Tennessee Department of Mental Health and Substance Abuse Services and/or its representative for review.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on August 1, 2014. The first 60 days of the cycle are assigned to the Department of the reviewing agency, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the 60-day period, a written report from the reviewing agency or its representative will be forwarded to this office for Agency review within the 30-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on October 22, 2014.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

- (1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.
- (2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,



Melanie M. Hill
Executive Director

MMH:mab

cc: Trent Sansing, CON Director, Office of Policy, Planning and Assessment, TDOH
Sandra (Sandy) Braber-Grove, Esq., Assistant General Counsel, TDMH



State of Tennessee

Health Services and Development Agency

Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243

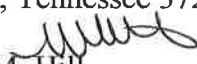
www.tn.gov/hsda

Phone: 615-741-2364

Fax: 615-741-9884

MEMORANDUM

TO: Sandra Braber-Grove, Esq.
Director, Privacy Compliance Officer/Assistant General Counsel
Division of General Counsel
Tennessee Department of Mental Health and Substance Abuse Services
5th Floor, Andrew Jackson Building
502 Deaderick Street
Nashville, Tennessee 37243

FROM: Melanie M. Hill 
Executive Director

DATE: August 1, 2014

RE: Certificate of Need Application
River Park Hospital, LLC — CN1407-030

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on August 1, 2014 and end on October 1, 2014.

Should there be any questions regarding this application or the review cycle, please contact this office.

MMH:mab

Enclosure

cc: Joseph Mazzo, COO
Trent Sansing, CON Director, Office of Policy, Planning and Assessment, TDOH



**State of Tennessee
Health Services and Development Agency**

Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

www.tn.gov/hsda

Phone: 615-741-2364

Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Southern Standard which is a newspaper
(Name of Newspaper)
of general circulation in Warren, Tennessee, on or before July 9, 2014,
(County) (Month / day) (Year)
for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

River Park Hospital, LLC an existing Hospital
(Name of Applicant) (Facility Type-Existing)
owned by: Capella Healthcare, Inc. with an ownership type of For-Profit Corporation
and to be managed by: River Park Hospital intends to file an application for a Certificate of Need
for [PROJECT DESCRIPTION BEGINS HERE]: the initiation of geriatric psychiatric services at River Park Hospital. The
project proposes the conversion of ten (10) of the hospital's existing licensed general medical/surgical beds to
geriatric psychiatric beds. Renovation of approximately 5,066 square feet of existing space on the third floor
of River Park Hospital will be required. No new beds or major medical equipment are being requested for the
project. The total cost of the project is estimated to be \$1,199,250.
The anticipated date of filing the application is: July 14, 2014
The contact person for this project is Joseph Mazzo Chief Operating Officer
(Contact Name) (Title)
who may be reached at: River Park Hospital 1559 Sparta Street
(Company Name) (Address)
McMinnville TN 37110 931 / 815-4203
(City) (State) (Zip Code) (Area Code / Phone Number)
Joseph Mazzo 7/3/14 Joseph.Mazzo@cappellahealth.com
(Signature) (Date) (E-mail Address)

The Letter of Intent must be **filed in triplicate** and **received between the first and the tenth day of the month**. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

**Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243**

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

SUPPLEMENTAL - #2

-COPY-

River Park Hospital

CN1407-030



River Park
Hospital

In partnership with Saint Thomas Health

SUPPLEMENTAL #2

July 30, 2014

9:54 am

July 29, 2014

Phillip Earhart, Health Services Examiner
Health Services Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

RE: Certificate of Need Application CN1407-030
River Park Hospital
Supplemental Response 2

Dear Mr. Earhart:

Thank you for your letter of July 25, 2014 acknowledging your July 24, 2014 receipt of River Park Hospital's application for a Certificate of Need for the initiation of inpatient geriatric psychiatric services and the conversion of ten (10) medical/surgical beds to geriatric psychiatric beds.

As requested, River Park Hospital is submitting its responses in triplicate by 4:00 p.m., Tuesday, July 29, 2014.

1. Section B, Project Description, Item I.

The response if the proposed unit will offer a partial hospitalization service and/or outpatient program is noted. However, please list all geriatric intensive outpatient and partial hospitalization programs in the proposed service area. This will demonstrate the psychiatric continuum of care that is available.

Response: Given the population size within the proposed service area and the limited inpatient services offered, we believe an inpatient program is the most appropriate course of action for geriatric patients with medical co-morbidities. Comprehensive psychiatric services are extremely limited in the proposed service area. The proposed inpatient program at River Park Hospital will complement the following outpatient services. Volunteer Behavioral Health Care System CHEER Mental Health Center in McMinnville provides intensive outpatient services for co-occurring disorders, outpatient therapy (for individuals, families and groups) and psychiatric medication management, among other services. River Park Hospital intends to supplement its proposed inpatient program with intensive outpatient and partial hospitalization programs as demand grows.

July 30, 2014**9 :54 am****2. Section B., Project Description, Item IV. (Floor Plan)**

Your response to this item is noted. Please clarify the reason why eight of the ten beds are located on the opposite end of the hallway out of direct view of the nurse's station.

Please clarify where family visits will take place.

Please clarify where medications will be stored.

Response: The beds were located on the other end of the hallway due to the layout, in which this was the only way to retrofit 10 beds into one wing. The visits will take place in the patient room or the quiet room if otherwise deemed necessary. The medications will be stored in the room directly behind the nursing station, which is currently not labeled.

3. Section C., Economic Feasibility, Item 4 (Projected Data Chart)

The Projected Data Chart for River Park Hospital is noted. However, please clarify why are there no taxes assigned on either the Projected Data Chart for the proposed geriatric psychiatric unit or the hospital's Projected Data Chart?

It is noted the management fee of \$617,914 and interest in the amount of \$3,390,976 is assigned in Year One of the Projected Data Chart for River Park Hospital. Please explain why there are no interest or management fees allocated to the proposed project's Projected Data Chart.

The applicant indicates a portion of the \$6,000 rent is allocated to a medical office building. Please clarify if this space is for storage, non-patient use, etc.

Response: The consolidated River Park is showing a net loss. No income taxes would be due, per the project loss in 2015 \$1.6 million and 2016 \$1.0 million. The Geri-Psych project is a department that rolls into a consolidated report.

The management fee and interest is for the consolidated River Park only. The Geri-Psych program is projected to be funded via cash flow, so there is no additional interest expense. The management fee is calculated by our corporate office annually.

Lastly, the \$6,000 is related to the copier rental, not the medical office building.

4. Section C. (Economic Feasibility) 6.B.

The charge data chart in the supplemental is noted. However, please provide similar information for the psychiatric units at Stones River Hospital, Southern Tennessee Medical Center, Grandview Medical Center, Riverview Hospital-South, and McFarland Hospital. Please use the 2012 Department of Health final Joint Annual Report as your source of data.

July 30, 2014**9 :54 am**

Response: Please refer to the table below.

Average Gross Charge Per Patient Day

Facility	Source	Charge
River Park Hospital	2015 Projection	\$2,825
Highlands Medical Center	2013 Actual	\$2,800
Rolling Hills Hospital	CN1312-051	\$1,534
Senior Health of Rutherford	CN1207-031	\$1,106
Parkridge Valley Hospital	CN1202-006	\$1,713
Select Specialty Hospital-Nashville	CN1210-053	\$3,397
Stones River Hospital	JAR, 2012	\$1,435
Southern TN Medical Center	JAR, 2012	\$1,885
Grandview Medical Center	JAR, 2012	\$1,998
Riverview Hospital - South	JAR, 2012	\$1,578
McFarland Hospital	JAR, 2012	\$1,425

5. Section C. Orderly Development, Item 3

Please clarify if a psychiatric tech-clinical aid is the same as a nursing assistant as listed in Exhibit 12 on page 42 of the original application.

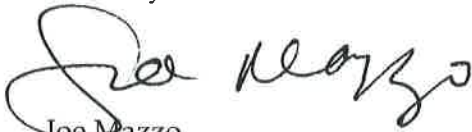
What will be the patient to staff ratio for the 7-3, 3-11 and 11-7 shifts?

The applicant has allocated a 1.0 FTE for an ER Assessment RN. Please clarify if this position will only assess geriatric patients, or any psychiatric patient that presents to the ER.

Response: The psychiatric tech is the same as the nursing assistant. The staffing will work in 12 hour shifts (day/night). The day shift will consist of 2 RN's and 1 NA for a 5:1 ratio. The night shift will consists of 1 RN, 1 NA, and 1 LPN equal to a 5:1 ratio. The ER assessment RN will assess all patients with behavioral health complaints.

Should you have any questions or require additional information, please do not hesitate to contact me.
As required, a signed affidavit attesting to this information is attached.

Sincerely,



Joe Mazzo

Chief Operating Officer

cc: Warren Gooch
Bob Limyansky

July 30, 2014

9 :54 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF WARREN

NAME OF FACILITY: RIVER PARK Hospital

I, Joseph MAZZO, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Joseph Mazzo COO
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 28 day of July, 2014, witness my hand at office in the County of White, State of Tennessee.

Angie L. Dodson
NOTARY PUBLIC

My commission expires June 19, 2018.

HF-0043

Revised 7/02





State of Tennessee

Health Services and Development Agency

Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243

www.tn.gov/hsda Phone: 615-741-2364/Fax:615/532-9940

July 17, 2014

Joseph Mazzo
Chief Operating Officer
River Park Hospital
1559 Sparta Street
McMinnville, TN 37110

RE: Certificate of Need Application CN1407-030
River Park Hospital

Dear Mr. Mazzo:

This will acknowledge our July 14, 2014 receipt of your application for a Certificate of Need for the initiation of inpatient geriatric psychiatric services and the conversion of ten (10) medical/surgical beds to geriatric psychiatric beds.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 4:00 p.m., Thursday July 24, 2014. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

1. Section A, Applicant Profile, Item 4.

The applicant in Item 1 is listed as an LLC, yet the box checked here is for-profit corporation. Please explain and make any corrections, if necessary, and submit a replacement page.

If the applicant is an LLC, please identify each of the LLC members and each member's percentage of ownership.

2. Section A, Applicant Profile, Item 13.

You have indicated that that River Park Hospital's relationship with TennCare MCOs is out-of-network with Americhoice and in-network with Amerigroup. According to TennCare's website there are two other MCOs besides Amerigroup, United Healthcare Community Plan and TennCare Select. Please describe your relationship with these two TennCare MCOs.

3. Section B, Project Description, Item I.

Please describe the services that will be provided on the proposed unit and explain how the space as identified on the floor plan, i.e., quiet, group, and noisy rooms, etc. will be used to provide the services identified.

It appear the 10 beds will be located in five semi-private rooms? If that is correct please discuss the pros and cons of providing inpatient psychiatric care in a private vs. semi-private room.

Please clarify if the proposed geropsychiatric unit will admit patients who are dually diagnosed with a psychiatric and chemical dependency diagnosis.

Please clarify if the proposed unit will admit patients with intellectual disabilities.

Will the proposed unit offer a partial hospitalization service and/or outpatient program?

4. Section B., Project Description, Item II. A.

Please clarify if there will be a secured area for triage and assessment.

Please clarify if the proposed psychiatric unit will have restraint rooms.

What type of safeguards will be provided to insure the geriatric psychiatric unit's safety and security? Will the unit be locked? What renovations to the existing medical/surgical area will take place to address these concerns?

5. Section B., Project Description, Item III.A. (Plot Plan)

Your response to this item is noted. Please submit a revised plot plan that displays the approximate location of the proposed geropsychiatric unit in the hospital.

6. Section B, Project Description, Item III.B.

Please complete the following chart by providing the estimated travel time/distance from the facilities listed to the selected municipalities.

Hospital	Psych Beds	McMinnville	Smithville	Sparta	Spenser	Altamount	Manchester
River Park Hospital	10*						
White Community Hospital	10						
Stones River Hospital	22						
Southern TN Medical Center	12						
Ten Broeck Hospital	32						
Grandview Hospital	18						
McFarland Hospital	49						
Riverview- South Hospital	10						

**Proposed*

7. Section C, Need, Item 1 (State Health Plan)

Your response to the 5 Principles for Achieving Better Health is noted. Please expand your response to address the following questions.

1. The purpose of the State Health Plan is to improve the health of Tennesseans.
 - a. How will this proposal protect, promote, and improve the health of Tennesseans over time?
 - b. What health outcomes will be impacted and how will the applicant measure improvement in health outcomes?
 - c. How does the applicant intend to act upon available data to measure its contribution to improving health outcomes?
2. Every citizen should have reasonable access to health care.
 - a. How will this proposal improve access to health care? You may want to consider geographic, insurance, use of technology, and disparity issues (including income disparity), among others.
 - b. How will this proposal improve information provided to patients and referring physicians?
 - c. How does the applicant work to improve health literacy among its patient population, including communications between patients and providers?

3. The State's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the State's health care system.
 - a. How will this proposal lower the cost of health care?
 - b. How will this proposal encourage economic efficiencies?
 - c. What information will be made available to the community that will encourage a competitive market for health care services?
4. Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.
 - a. How will this proposal help health care providers adhere to professional standards?
 - b. How will this proposal encourage continued improvement in the quality of care provided by the health care workforce?
5. The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.*
 - a. How will this proposal provide employment opportunities for the health care workforce?
 - b. How will this proposal complement the existing Service Area workforce?
8. **Section C., Need, 1. Specific Criteria (Inpatient Psychiatric Units) Item A Need 1-4.**

Your response to this item is noted. Did the applicant exclude out of state admissions in determining the use rate for Tennessee? What was the statewide occupancy rate for inpatient psychiatric services in 2012?

Since the current bed need formula in the Guidelines for Growth is what is in effect, please calculate bed need using this bed need formula and including the use of population projections calculated by the Tennessee Department of Health for Year 2018 adult bed need and geriatric bed need.

Please also calculate adult and geriatric bed need under the following scenarios:

- Include adjacent Cannon County and the psychiatric beds at Stones River Hospital
- Calculate a bed need using only Warren County, where according to the 2012 Joint Annual Report, 82% of River Park Hospital's inpatients reside.

9. Section C., Need, 1. Specific Criteria (Inpatient Psychiatric Units) Item C.2.

Please indicate the designated Medically Underserved Areas of the proposed service area as designated by the U.S. Health Resources and Services Administration.

10. Section C., Need, 1. Specific Criteria (Inpatient Psychiatric Units) Item C.3

What impact the will the proposed project have on Middle Tennessee Mental Health Institute in Nashville and/or Moccasin Bend Mental Health Institute in Chattanooga?

11. Section C., Need, Item 3

Please complete the following patient origin chart for River Park Hospital:

River Park Patient Origin-2013

County	Admissions	%Total
Coffee		
DeKalb		
Grundy		
Van Buren		
Warren		
White		
Cannon		
Other		
Total		

According to data from the 2012 Joint Annual Report other than a 45.6% market share in Warren County and a 12.1% market share in Van Buren County, River Park Hospital had less than 10% inpatient market share in the other four counties (Coffee, Grundy, DeKalb, and White) of its declared service area. Please provide further justification for including these four counties in the applicant's declared service area.

12. Section C., Need, Item 4.A.

Your response to this item is noted. Please complete the following chart using population projections provided by the Department of Health and US Census:

Demographic Data	Coffee County	DeKalb County	Grundy County	Van Buren County	Warren County	White County	Service Area Total	State of TN Total
Total 2014 Population								
Total Population-								
Total 2014 Population % Change								
65+ Pop. - 2014								
65+ Pop. - 2018								
65+ Population % Change								
65+ Population % of Total Population								
Median Age								
Median Household Income								
TennCare Enrollees								
TennCare Enrollees as % of Total Population								
Persons Below Poverty Level								
% of Total Population below Poverty Level								

13. Section C., Need, Item 5.

Your response to this item is noted. Please expand your other area provider information by completing the following chart:

Facility	Psychiatric Beds	2010 Patient Days (PDs)	2011 PDs	2012 PDs	2013 PDs	2010-2013 % chng.	2010 % Occ.	2011 % Occ.	2012 % Occ.	2013 % Occ.	Accepts Involuntary Admits?
Highlands MC											
Stones River MC											
So. TN MC											
Grandview MC											
Ten Broeck MC											
Riverview											
McFarland											

14. Section C., Need, Item 6. (The Applicant's Historical and Projected Utilization)

Your response to this item is noted: Please expand your projected utilization data by completing the following charts:

River Park Hospital Projected Inpatient Psychiatric Utilization

Measure	2015	2016
Beds		
Age 0-54 Admissions		
Age 55-64 Admissions		
Age 65+ Admissions		
Total Admissions		
Age 0-54 Patient Days		
Age 55-64 Patient Days		
Age 65+ Patient Days		
Total Patient Days		
Average Length of Stay		
% Occupancy		

Please provide the details regarding the methodology used to project the utilization in the above chart. The methodology must include detailed calculations or documentation from referral sources. Providing only statements such as “based on past experience” will not be considered an adequate response.

River Park Hospital Historical Inpatient Utilization

Licensed Beds	2010 Patient Days (PDs)	2011 PDs	2012 PDs	2013 PDs	2010-2013 % chng.	2010 % Occ.	2011 % Occ.	2012 % Occ.	2013 % Occ.

15. Section C., Economic Feasibility, Item 4 (Historical Data Chart)

The applicant’s Historical Data Chart indicates that River Park Hospital reported net operating losses of \$4,143,969 and \$4,428,017 in Years 2012 and 2013, respectively. Please discuss in detail the impact of the hospital’s financial position on the financial feasibility of the proposed project.

16. Section C., Economic Feasibility, Item 4 (Projected Data Chart)

Does the applicant plan to hire a medical director for the geropsychiatric unit? If yes, please explain why there are no physician salaries and wages reported. Please explain why there are no taxes, interest, or management fees allocated to the proposed project.

Please explain the \$6,000 listed for Rent

Please provide a Projected Data Chart for River Park Hospital in total.

17. Section C. (Economic Feasibility) 6.B.

The charge data from Highlands Medical Center is noted. Please provide similar information for the psychiatric units at Stones River Hospital, Southern Tennessee Medical Center, Grandview Medical Center, Riverview Hospital-South, and McFarland Hospital.

18. Section C. (Economic Feasibility) Item 9.

Please complete the following chart for the proposed geriatric psychiatric unit:

Payor	2016 Gross Revenue	% of Total Revenues
Medicare		
Medicaid/TennCare		
Commercial insurance		
Self-Pay		
Total		

19. Section C. (Economic Feasibility) Item 10

According to the Capella Healthcare financial statements provided, Capella Healthcare reported a net loss of \$31.8 million on December 31, 2013. Please discuss what impact the net loss will have on the financial feasibility of the proposed project.

20. Section C. Orderly Development, Item 3

The applicant has indicated that the staffing for the geropsychiatric unit is planned to be filled internally by existing staff in the Capella system. Does existing staff have experience in psychiatric nursing and/or specific training and/or certifications in psychiatric nursing? If not what is the level of difficulty in recruiting nurses with experience in psychiatry? Please discuss.

Has the applicant selected a medical director for the unit? If yes please provide this individual's curriculum vitae and documentation of applicable Board certifications. If not, what is the applicant's recruiting plans for hiring a qualified physician for this post?

Will the staffing for the unit include LPEs (Licensed Psychological Examiners), Psychologists, LCSWs (Licensed Clinical Social Workers), Master's Level Therapist, etc.?

21. Section C. Orderly Development, Item 7

Your response to this item is noted. Please file the most recent complete survey report filed by the Joint Commission.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is September 15, 2014. If this application is not deemed complete by this date, the application will be deemed void.**

Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

- (1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.
- (2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,



Mark Farber
Deputy Director

Enclosure/MAF



State of Tennessee

Health Services and Development Agency

Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243

www.tn.gov/hsda Phone: 615-741-2364/Fax: 615/532-9940

July 28, 2014

Joseph Mazzo
Chief Operating Officer
River Park Hospital
1559 Sparta Street
McMinnville, TN 37110

RE: Certificate of Need Application CN1407-030
River Park Hospital

Dear Mr. Mazzo:

This will acknowledge our July 24, 2014 receipt of your supplemental response for the initiation of inpatient geriatric psychiatric services and the conversion of ten (10) medical/surgical beds to geriatric psychiatric beds.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 4:00 p.m., Thursday July 29, 2014. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

1. Section B, Project Description, Item I.

The response if the proposed unit will offer a partial hospitalization service and/or outpatient program is noted? However, please list all geriatric intensive outpatient and partial hospitalization programs in the proposed service area. This will demonstrate the psychiatric continuum of care that is available.

2. Section B., Project Description, Item IV. (Floor Plan

Your response to this item is noted. Please clarify the reason why eight of the ten beds are located on the opposite end of the hallway out of direct view of the nurse's station.

Please clarify where family visits will take place.

Please clarify where medications will be stored.

3. Section C., Economic Feasibility, Item 4 (Projected Data Chart)

The Projected Data Chart for River Park Hospital is noted. However, please clarify why are there no taxes assigned on either the Projected Data Chart for the proposed geriatric psychiatric unit or the hospital's Projected Data Chart?

It is noted the management fee of \$617,914 and interest in the amount of \$3,390,976 is assigned in Year One of the Projected Data Chart for River Park Hospital. Please explain why there are no interest or management fees allocated to the proposed project's Projected Data Chart.

The applicant indicates a portion of the \$6,000 rent is allocated to a medical office building. Please clarify if this space is for storage, non-patient use, etc.

4. Section C. (Economic Feasibility) 6.B.

The charge data chart in the supplemental is noted. However, please provide similar information for the psychiatric units at Stones River Hospital, Southern Tennessee Medical Center, Grandview Medical Center, Riverview Hospital-South, and McFarland Hospital. Please use the 2012 Department of Health final Joint Annual Report as your source of data.

5. Section C. Orderly Development, Item 3

Please clarify if a psychiatric tech-clinical aid is the same as a nursing assistant as listed in Exhibit 12 on page 42 of the original application.

What will be the patient to staff ratio for the 7-3, 3-11 and 11-7 shifts?

The applicant has allocated a 1.0 FTE for an ER Assessment RN. Please clarify if this position will only assess geriatric patients, or any psychiatric patient that presents to the ER.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is September 15, 2014. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

- (1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.
- (2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,



Phillip M. Earhart
Health Services Examiner

Enclosure/PME

COPY- SUPPLEMENTAL-1

**River Park Hospital
CN1407-030**



In partnership with Saint Thomas Health

SUPPLEMENTAL- # 1

July 24, 2014

3:05pm

July 23, 2014

Mark Farber, Deputy Director
Health Services Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

RE: Certificate of Need Application CN1407-030
River Park Hospital
Supplemental Response

Dear Mr. Farber:

Thank you for your letter of July 17, 2014 acknowledging your July 14, 2014 receipt of River Park Hospital's application for a Certificate of Need for the initiation of inpatient geriatric psychiatric services and the conversion of ten (10) medical/surgical beds to geriatric psychiatric beds.

As requested, River Park Hospital is submitting its responses in triplicate by 4:00 p.m., Thursday, July 24, 2014.

1. Section A, Applicant Profile, Item 4.

The applicant in Item 1 is listed as an LLC, yet the box checked here is for-profit corporation. Please explain and make any corrections, if necessary, and submit a replacement page.

If the applicant is an LLC, please identify each of the LLC members and each member's percentage of ownership.

Response: The applicant, River Park Hospital, is a Limited Liability Company with its two members consisting of Capella Healthcare, Inc. (93.51% owner) and Saint Thomas Health (6.49% owner). The majority owner of control of River Park Hospital, LLC is Capella Healthcare, Inc. (as listed in Item 3) which is a for-profit corporation (as originally listed in Item 4). The minority owner of River Park Hospital, LLC is Saint Thomas Health which is a non-profit corporation. Section A, Item 4 was originally filled out addressing the entity status of the majority owner of control, not the applicant. Please see the organizational chart included at Tab 2 of the original CON application. Note that Capella and Saint Thomas hold their ownership of River Park Hospital through an intermediate entity - Saint Thomas / Capella, LLC.

Additionally, please see **Attachment A** for a replacement page as requested above which corrects the Type of Ownership of Control.

2. Section A, Applicant Profile, Item 13.

You have indicated that that River Park Hospital's relationship with TennCare MCOs is out-of-network with Americhoice and in-network with Amerigroup. According to TennCare's website there are two other MCOs besides Amerigroup, United Healthcare Community Plan and TennCare Select. Please describe your relationship with these two TennCare MCOs.

Response: As indicated in the MCO/BHO Participation list on Bates pages 0085-0086, River Park Hospital also participates in the United Healthcare Community Plan and TennCare Select. A corrected Bates page 0006 is included here (**Attachment B**).

3. Section B, Project Description, Item I.

Please describe the services that will be provided on the proposed unit and explain how the space as identified on the floor plan, i.e., quiet, group, and noisy rooms, etc. will be used to provide the services identified.

Response: The proposed unit is designed to focus on elderly medical-surgical patients with a dual psychiatric disorder. Such patients often suffer from dementia, Alzheimer's and conditions involving drug interactions and reactions. The floor plan allows for separation of patients who might become temporarily agitated, withdrawn or depressed.

It appears the 10 beds will be located in five semi-private rooms? If that is correct please discuss the pros and cons of providing inpatient psychiatric care in a private vs. semi-private room.

Response: The 10 beds will actually be located in 4 semi-private rooms (8 beds) and 2 private rooms (2 beds). Thus, River Park will offer options of both semi-private and private rooms, depending upon patient needs. Patients requiring socialization skills will be kept in semi-private rooms while those exhibiting disruptive behaviors are better suited for the private rooms.

Please clarify if the proposed geropsychiatric unit will admit patients who are dually diagnosed with a psychiatric and chemical dependency diagnosis.

Response: No. River Park Hospital will focus on patients with dual medical-surgical and psychiatric diagnoses.

Please clarify if the proposed unit will admit patients with intellectual disabilities.

Response: The proposed unit will be open to all appropriate patients, including those with intellectual disabilities. However, the unit will not emphasize care for these types of patients.

Will the proposed unit offer a partial hospitalization service and/or outpatient program?

Response: No. Instead, River Park Hospital will coordinate outpatient services with three existing programs in McMinnville: Womacks Community Care Home, Volunteer

Behavioral Health Care System CHEER Mental Health Center and Generations Mental Health Center. There are four other providers within twenty-five miles as well. 2:05pm

4. Section B., Project Description, Item II. A.

Please clarify if there will be a secured area for triage and assessment.

Response: Triage and assessment will be done within a secured area in the emergency department.

Please clarify if the proposed psychiatric unit will have restraint rooms.

Response: The proposed psychiatric unit will have a quiet room, a noisy room and two other private bedrooms which can be suited for temporarily restraining patients.

What type of safeguards will be provided to insure the geriatric psychiatric unit's safety and security? Will the unit be locked? What renovations to the existing medical/surgical area will take place to address these concerns?

Response: A new, secure entry (locked) will be created on the unit to better assure patient safety. Renovations will include new doors, observation windows, nursing station, closed circuit television cameras, etc.

5. Section B., Project Description, Item III.A. (Plot Plan)

Your response to this item is noted. Please submit a revised plot plan that displays the approximate location of the proposed geropsychiatric unit in the hospital.

Response: Please see **Attachment C** for a revised plot plan (Bates page 0090) that displays the approximate location of the proposed geropsychiatric unit in the hospital.

6. Section B, Project Description, Item III.B.

Please complete the following chart by providing the estimated travel time/distance from the facilities listed to the selected municipalities.

Hospital	Psych Beds	McMinnville	Smithville	Sparta	Spenser	Altamount	Manchester
River Park Hospital	10*	-	20.9 mi/ 28 min	25.7 mi/ 27 min	18.2 mi/ 23 min	29.1 mi/ 39 min	27.5 mi/ 33 min
White Community Hospital (Highlands MC)	10	29.3 mi/ 33 min	21.2 mi/ 26 min	-	15 mi/ 19 min	56.9 mi/ 66 min	53.9 mi/ 60 min
Stones River Hospital	22	21.3 mi/ 29 min	20.4 mi/ 32 min	41.5 mi/ 57 min	41.7 mi/ 55 min	43.2 mi/ 59 min	25.2 mi/ 32 min
Southern TN Medical Center	12	43.6 mi/ 59 min	63.1 mi/ 84 min	70.8 mi/ 88 min	57.1 mi/ 64 min	35.4 mi/ 45 min	45.8 mi/ 43 min
Ten Broeck Hospital (Cookeville RMC)	32	46.7 mi/ 53 min	28.2 mi/ 35 min	20.0 mi/ 25 min	32.4 mi/ 36 min	74.2 mi/ 81 min	71.3 mi/ 78 min
Grandview Hospital	18	69.2 mi/ 68 min	87.9 mi/ 91 min	70.8 mi/ 80 min	57.1 mi/ 64 min	33.4 mi/ 45 min	45.8 mi/ 43 min
McFarland Hospital	49	54.7 mi/ 67 min	35.3 mi/ 41 min	66.1 mi/ 60 min	78.4 mi/ 71 min	92.5 mi/ 91 min	67.3 mi/ 59 min
Riverview-South Hospital	10	54.5 mi/ 68 min	35 mi/ 41 min	53 mi/ 53 min	65.3 mi/ 64 min	81.5 mi/ 101 min	64.8 mi/ 79 min

*Proposed

7. Section C, Need, Item 1 (State Health Plan)

Your response to the 5 Principles for Achieving Better Health is noted. Please expand your response to address the following questions.

1. The purpose of the State Health Plan is to improve the health of Tennesseans.
 - a. How will this proposal protect, promote, and improve the health of Tennesseans over time?
 - b. What health outcomes will be impacted and how will the applicant measure improvement in health outcomes?
 - c. How does the applicant intend to act upon available data to measure its contribution to improving health outcomes?

Response: This project will improve access to mental health care for the elderly population of the service area. Specifically, it will enhance the availability and quality of these specialized geri psych services within an existing hospital to meet the needs of elderly psych patients, including those with a dual diagnosis. According to federal statistics,

- Approximately 30% of hospital admissions of older adults are drug related, with more than 11% attributed to medication nonadherence and 10–17 % related to adverse drug reactions (ADRs).¹
- Older adults discharged from the hospital on more than five drugs are more likely to visit the emergency department (ED) and be rehospitalized during the first 6 months after discharge.
- In elderly individuals, delirium can initiate or otherwise be a key component in a cascade of events that lead to a downward spiral of functional decline, loss of independence, institutionalization, and, ultimately, death. Delirium affects an estimated 14–56% of all hospitalized elderly patients. At least 20% of the 12.5 million patients over 65 years of age hospitalized each year in the US experience complications during hospitalization because of delirium.²

In addition, as patients age and/or spouses die, they become more isolated and often develop depression. Patients presenting at the hospital must be treated for both medical-surgical and psychiatric conditions. Presently, River Park Hospital lacks such dedicated facilities. Mixing these types of patients within the general hospital population is not optimal for either group.

The approval of this project will give the applicant the ability to collaborate with other local medical providers to treat these difficult patients, and contribute to improved health outcomes in the service area.

2. *Every citizen should have reasonable access to health care.*

- a. *How will this proposal improve access to health care? You may want to consider geographic, insurance, use of technology, and disparity issues (including income disparity), among others.*
- b. *How will this proposal improve information provided to patients and referring physicians?*
- c. *How does the applicant work to improve health literacy among its patient population, including communications between patients and providers?*

¹ Marek KD, Antle L. Medication Management of the Community-Dwelling Older Adult. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 18. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK2670/>

² Tamara G. Fong, Samir R. Tulebaev & Sharon K. Inouye. Delirium in elderly adults: diagnosis, prevention and treatment. Nature Reviews Neurology 5, 210-220 (April 2009). doi:10.1038/nrneuro.2009.24

Response: This project will improve access to elderly patients requiring psychiatric services in the service area. There are currently no other geri psych services offered in the service area. The beds will be accessible to anyone in need of such services, regardless of their gender, race, ethnicity or ability to pay. As the service is proposed in an area where no other such services currently exist, it will prevent local patients from having to travel great distances to receive the care they need. With the proposed geri psych program, River Park Hospital is committed to serving all patients in need, including low income patients in the TennCare and Medicare programs, just as it has done historically.

3. *The State's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the State's health care system.*

- a. *How will this proposal lower the cost of health care?*
- b. *How will this proposal encourage economic efficiencies?*
- c. *What information will be made available to the community that will encourage a competitive market for health care services?*

Response: This project supports the State's goals of encouraging competitive markets, economic efficiencies, and the development of the State's health care system. It will help reduce readmissions and emergency department visits by the elderly associated with adverse drug reactions, delirium and other psychiatric co-morbidities. By developing the service in renovated space at the hospital, it is far more economic and efficient than new construction. Through the conversion of existing beds that are currently unstaffed, the project will provide a valuable service to the patients in the service area that is not currently offered by any other provider, while better utilizing existing hospital resources. This will prevent patients in need of the service from having to travel outside of the area for care, saving time and money in travel.

4. *Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.*

- a. *How will this proposal help health care providers adhere to professional standards?*
- b. *How will this proposal encourage continued improvement in the quality of care provided by the health care workforce?*

Response: River Park Hospital is a state licensed facility that is also accredited by The Joint Commission. It is fully compliant with the operational standards of the industry with respect to quality of care measures, and continually monitors these applicable standards to assure that it always meets or exceeds them. This assures the hospital's patients always receive appropriate, high quality care.

5. *The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.*

- a. *How will this proposal provide employment opportunities for the health care workforce?*
- b. *How will this proposal complement the existing Service Area workforce?*

Response: River Park Hospital supports the development, recruitment, and retention of a sufficient and quality healthcare workforce through various training programs, community outreach initiatives, and other programs. The approval of this project would result in the recruitment of additional professional staff.

8. Section C., Need, 1. Specific Criteria (Inpatient Psychiatric Units) Item A Need 1-4.

Your response to this item is noted. Did the applicant exclude out of state admissions in determining the use rate for Tennessee? What was the statewide occupancy rate for inpatient psychiatric services in 2012?

Response: It is believed that the hospital JAR summary data provided by the Health Statistics Section of the Tennessee Department of Health did not exclude out of state admissions. Nor, however, did it include the offset for Tennessee residents seeking care outside the state. The applicant does not have access to the raw data to make such adjustments possible. Furthermore, a query of the Tennessee Hospital Association's discharge database suggested too much incomplete data to make reliable estimates from this source.

The statewide occupancy rate for the 2,495 general psychiatric beds was 65.3% in 2012. Since many of the state's psychiatric programs have small units of 10-12 beds, the occupancy rate does not appear to be unreasonably high or low.

Since the current bed need formula in the Guidelines for Growth is what is in effect, please calculate bed need using this bed need formula and including the use of population projections calculated by the Tennessee Department of Health for Year 2018 adult bed need and geriatric bed need.

Response: Psychiatric services are more regional in nature than general acute hospital services. Therefore, expanding beyond Warren County is reasonable, as is excluding adjacent counties where patients can receive such services at their local hospital. Thus, the original service area and bed need projected in the application is reasonable.

That said, please find the tables below for the requested bed need calculations utilizing the state's current bed need formula and Tennessee Department of Health Populations for 2018.

	Population				Beds								
	2018				Gross Need			Existing Inventory			Net Need		
	Total	Adult 20+	Geri 55+		Total	Adult 20+	Geri 55+	Total	Adult 20+	Geri 55+	Total	Adult 20+	Geri 55+
Coffee	56,841	42,745	13,726		17.1	12.8	4.1	0	0	0	17.1	12.8	4.1
DeKalb	19,125	14,517	6,340		5.7	4.4	1.9	0	0	0	5.7	4.4	1.9
Grundy	13,293	10,101	4,555		4.0	3.0	1.4	0	0	0	4.0	3.0	1.4
Van Buren	5,474	4,313	2,084		1.6	1.3	0.6	0	0	0	1.6	1.3	0.6
Warren	41,155	30,575	12,562		12.3	9.2	3.8	0	0	0	12.3	9.2	3.8
White	27,974	21,022	8,868		8.4	6.3	2.7	0	0	10	8.4	6.3	(7.3)
Service Area	163,862	123,273	48,135		49.2	37.0	14.4	0	0	10	49.2	37.0	4.4

Utilizing the state's bed need methodology, there is a net need for 4.4 geri psych beds in the service area at full utilization. Applying the same 70% utilization standard as in the original CON application results in a need for an 8 bed program ($4.4 \div 70\% = 6.3 = 7 + 1$ seclusion bed = 8 beds). As psychiatric services are more regional in nature than general acute hospital services, the applicant expects a fair amount of in-migration of patients from outside of the service's home county. This fact certainly bolsters the need for the initiation of the proposed 10 bed service at River Park Hospital.

Please also calculate adult and geriatric bed need under the following scenarios:

- *Include adjacent Cannon County and the psychiatric beds at Stones River Hospital*

	Population 2018				Gross Need			Existing Inventory			Net Need		
	Total	Adult 20+	Geri 55+		Total	Adult 20+	Geri 55+	Total	Adult 20+	Geri 55+	Total	Adult 20+	Geri 55+
Cannon	14,540	11,189	4,680		4.4	3.4	1.4	0	0	22	4.4	3.4	(20.6)
Coffee	56,841	42,745	13,726		17.1	12.8	4.1	0	0	0	17.1	12.8	4.1
DeKalb	19,125	14,517	6,340		5.7	4.4	1.9	0	0	0	5.7	4.4	1.9
Grundy	13,293	10,101	4,555		4.0	3.0	1.4	0	0	0	4.0	3.0	1.4
Van Buren	5,474	4,313	2,084		1.6	1.3	0.6	0	0	0	1.6	1.3	0.6
Warren	41,155	30,575	12,562		12.3	9.2	3.8	0	0	0	12.3	9.2	3.8
White	27,974	21,022	8,868		8.4	6.3	2.7	0	0	10	8.4	6.3	(7.3)
Service Area	178,402	134,462	52,815		53.5	40.3	15.8	0	0	32	53.5	40.3	(16.2)

- *Calculate bed need using only Warren County, where according to the 2012 Joint Annual Report, 82% of River Park Hospital's inpatients reside.*

	Population 2018				Gross Need			Existing Inventory			Net Need		
	Total	Adult 20+	Geri 55+		Total	Adult 20+	Geri 55+	Total	Adult 20+	Geri 55+	Total	Adult 20+	Geri 55+
Warren	41,155	30,575	12,562		12.3	9.2	3.8	0	0	0	12.3	9.2	3.8

Utilizing the state's bed need methodology, there is a net need for 3.8 geri psych beds in Warren County alone at full utilization. Applying the same 70% utilization standard as in the original CON application results in a need for a 7 bed program ($3.8 \div 70\% = 5.4 = 6 + 1$ seclusion bed = 7 beds). As psychiatric services are more regional in nature than general acute hospital services, the applicant expects a fair amount of in-migration of patients from outside of the service's home county. This fact certainly bolsters the need for the initiation of the proposed 10 bed service at River Park Hospital.

9. Section C., Need, 1. Specific Criteria (Inpatient Psychiatric Units) Item C.2.

Please indicate the designated Medically Underserved Areas of the proposed service area as designated by the U.S. Health Resources and Services Administration.

Response: All six of the proposed service area counties are Medically Underserved Areas. In addition, these six counties are designated as a Health Professional Shortage Area (HPSA) by the Health Resources and Services Administration (HRSA) as having a shortage of mental health providers. Please see **Attachment D** for documentation from the US Department of Health and Human Services, Health Resources and Services Administration website on 7/23/2014.

10. Section C., Need, 1. Specific Criteria (Inpatient Psychiatric Units) Item C.3

What impact will the proposed project have on Middle Tennessee Mental Health Institute in Nashville and/or Moccasin Bend Mental Health Institute in Chattanooga?

Response: As demonstrated in the need projections, the proposed geropsych service is expected to be utilized mostly by service area residents, and will therefore have a very minimal impact on the two facilities listed above. Further, these state facilities have 300 and 150 beds respectively, and both are located approximately 76 miles from River Park Hospital. The proposed 10 beds at River Park Hospital will have a minimal impact on these facilities. In addition, River Park Hospital is a more appropriate setting for patients with dual diagnoses of medical-surgical and psychiatric conditions where the continuity of patient care can be better coordinated with local physicians.

11. Section C., Need, Item 3

Please complete the following patient origin chart for River Park Hospital:

River Park Patient Origin-2013

County	Admissions	%Total
Coffee	60	1.9%
DeKalb	136	4.3%
Grundy	74	2.3%
Van Buren	57	1.8%
Warren	2,633	82.8%

White	109	3.4%
Cannon	47	1.5%
Other	65	2.0%
Total	3,181	100.0%

According to data from the 2012 Joint Annual Report other than a 45.6% market share in Warren County and a 12.1% market share in Van Buren County, River Park Hospital had less than 10% inpatient market share in the other four counties (Coffee, Grundy, DeKalb, and White) of its declared service area. Please provide further justification for including these four counties in the applicant's declared service area.

Response: Psychiatric services are more regional in nature than general acute hospital services. Therefore, expanding beyond Warren County is reasonable, as is excluding adjacent counties where patients can receive such services at their local hospital. Thus, the original service area and bed need projected in the application is reasonable.

12. Section C., Need, Item 4.A.

Your response to this item is noted. Please complete the following chart using population projections provided by the Department of Health and US Census:

Demographic Data	Coffee County	DeKalb County	Grundy County	Van Buren County	Warren County	White County	Service Area Total	State of TN Total
Total 2014 Population	54,273	18,952	13,355	5,450	40,489	26,871	159,390	6,588,698
Total Population-	56,841	19,125	13,293	5,474	41,155	27,974	163,862	6,833,509
Total 2014 Population % Change	4.7%	0.9%	-0.5%	0.4%	1.6%	4.1%	2.8%	3.7%
65+ Pop. - 2014	8,115	3,337	2,637	1,118	6,823	5,051	27,081	981,984
65+ Pop. - 2018	7,380	3,678	2,792	1,259	7,203	5,375	27,687	1,102,413
65+ Population % Change	-9.1%	10.2%	5.9%	12.6%	5.6%	6.4%	2.2%	12.3%
65+ Population % of Total Population	15.0%	17.6%	19.7%	20.5%	16.9%	18.8%	17.0%	14.9%
Median Age	40	41	41	45	39	42	41	38
Median Household Income	\$38,151	\$36,713	\$26,644	\$31,940	\$34,008	\$34,717	\$33,696	\$44,140
TennCare Enrollees	10,884	4,431	4,340	1,165	9,193	5,882	35,895	1,190,766
TennCare Enrollees as % of Total Population	20.1%	23.4%	32.5%	21.4%	22.7%	21.9%	22.5%	18.1%
Persons Below Poverty Level	11,180	3,601	3,873	1,221	9,272	5,401	34,548	1,139,845
% of Total Population below Poverty Level	20.6%	19.0%	29.0%	22.4%	22.9%	20.1%	21.7%	17.3%

13. Section C., Need, Item 5.

Your response to this item is noted. Please expand your other area provider information by completing the following chart:

Facility	Psychiatric Beds	2010 Patient Days (PDs)	2011 PDs	2012 PDs	2013 PDs	2010-2013 % chng.	2010 % Occ.	2011 % Occ.	2012 % Occ.	2013 % Occ.	Accepts Involuntary Admits?
Highlands MC	10	245	267	3,059	3,036	1,139.2%	6.7%	7.3%	83.8%	83.2%	Yes
Stones River MC	22	5,820	5,635	5,225	2,787	-52.1%	72.5%	70.2%	65.1%	34.7%	Yes
So. TN MC	12	3,725	3,820	3,778	3,475	-6.7%	85.0%	87.2%	86.3%	79.3%	No
Grandview MC	18	4,515	5,694	5,842	4,329	-4.1%	68.7%	86.7%	88.9%	65.9%	Yes
Ten Broeck MC	32										
Riverview	7	0	0	2,559	2,506				100.2%	98.1%	Yes
McFarland	49	8,500	13,780	8,500	7,239	-14.8%	47.5%	77.0%	47.5%	40.5%	Yes

14. Section C., Need, Item 6. (The Applicant's Historical and Projected Utilization)

Your response to this item is noted: Please expand your projected utilization data by completing the following charts:

River Park Hospital Projected Inpatient Psychiatric Utilization

Measure	2015	2016
Beds	10	10
Age 0-54 Admissions	0	0
Age 55-64 Admissions		
Age 65+ Admissions		
Total Admissions		
Age 0-54 Patient Days		
Age 55-64 Patient Days	459	550
Age 65+ Patient Days	1,834	2,202
Total Patient Days	2,293	2,752
Average Length of Stay	6.28	7.54
% Occupancy	62.8%	75.4%

Please provide the details regarding the methodology used to project the utilization in the above chart. The methodology must include detailed calculations or documentation from referral sources. Providing only statements such as "based on past experience" will not be considered an adequate response.

Response: After establishing service area bed need on pages 15 and 16 of the original CON application, River Park Hospital projected a gradual ramp up of services on the proposed 10 beds amounting to 62.8% occupancy in Year 1 and 75.4% occupancy in Year 2. Next, occupancy was converted to total patient days. Total patient days were distributed by age cohort according to the age distribution found in the general population.

River Park Hospital Historical Inpatient Utilization

Licensed Beds	2010 Patient Days (PDs)	2011 PDs	2012 PDs	2013 PDs	2010-2013 % chng.	2010 % Occ.	2011 % Occ.	2012 % Occ.	2013 % Occ.
125	14,921	13,695	11,625	11,395	-23.6%	32.7%	30.0%	25.4%	25.0%

15. Section C., Economic Feasibility, Item 4 (Historical Data Chart)

The applicant's Historical Data Chart indicates that River Park Hospital reported net operating losses of \$4,143,969 and \$4,428,017 in Years 2012 and 2013, respectively. Please discuss in detail the impact of the hospital's financial position on the financial feasibility of the proposed project.

Response: The applicant has the cash on hand to undertake the project. As is detailed in the Projected Data Chart, the projected geri psych service is expected to generate a positive return beginning immediately in Year 1 of operation. Revenue generating services like the proposed geri psych unit will help the hospital's financial position overall.

16. Section C., Economic Feasibility, Item 4 (Projected Data Chart)

Does the applicant plan to hire a medical director for the geropsychiatric unit? If yes, please explain why there are no physician salaries and wages reported. Please explain why there are no taxes, interest, or management fees allocated to the proposed project.

Response: The applicant does plan to hire a medical director. The medical director services will be provided under a professional services agreement. All administrative costs related to this service will be paid from by professional fees as listed as in D.9 professional fees under operating expenses.

Please explain the \$6,000 listed for Rent

Response: The rent includes: MOB rent, Pyxis equipment (medication dispensing equipment), ventilators, and copiers.

Please provide a Projected Data Chart for River Park Hospital in total.

Response: Please see **Attachment E** for a Projected Data Chart for River Park Hospital in total (existing hospital services plus proposed geri psych unit).

17. Section C. (Economic Feasibility) 6.B.

The charge data from Highlands Medical Center is noted. Please provide similar information for the psychiatric units at Stones River Hospital, Southern Tennessee Medical Center, Grandview Medical Center, Riverview Hospital-South, and McFarland Hospital.

Response: Please refer to the table below.

Average Gross Charge Per Patient Day

Facility	Source	Charge
River Park Hospital	2015 Projection	\$2,825
Highlands Medical Center	2013 Actual	\$2,800
Rolling Hills Hospital	CN1312-051	\$1,534
Senior Health of Rutherford	CN1207-031	\$1,106
Parkridge Valley Hospital	CN1202-006	\$1,713
Select Specialty Hospital-Nashville	CN1210-053	\$3,397

18. Section C. (Economic Feasibility) Item 9.

Please complete the following chart for the proposed geriatric psychiatric unit:

Payor	2016 Gross Revenue	% of Total Revenues
Medicare	\$4,062,510	49.3%
Medicaid/TennCare	\$1,870,567	22.7%
Commercial insurance	\$1,540,952	18.7%
Self-Pay	\$601,548	7.3%
Total	\$8,075,577	98.0%

19. Section C. (Economic Feasibility) Item 10

According to the Capella Healthcare financial statements provided, Capella Healthcare reported a net loss of \$31.8 million on December 31, 2013. Please discuss what impact the net loss will have on the financial feasibility of the proposed project.

Response: These are challenging times, especially for small rural hospitals. Over the last several years, Capella has been making adjustments to hospitals and the services offered to better serve their communities. Programs such as the one proposed here will bring needed resources to the community while strengthening Capella's financial position.

July 24, 2014

3:05pm

20. Section C. Orderly Development, Item 3

The applicant has indicated that the staffing for the geropsychiatric unit is planned to be filled internally by existing staff in the Capella system. Does existing staff have experience in psychiatric nursing and/or specific training and/or certifications in psychiatric nursing? If not what is the level of difficulty in recruiting nurses with experience in psychiatry? Please discuss.

Response: The staffing for the geropsychiatric unit will be filled internally by existing staff in the Capella system who are experienced and have specific training and certifications in psychiatric nursing. Capella has experience in recruiting and retaining high level staff.

Has the applicant selected a medical director for the unit? If yes please provide this individual's curriculum vitae and documentation of applicable Board certifications. If not, what is the applicant's recruiting plans for hiring a qualified physician for this post?

Response: The applicant has not selected a medical director for the unit, but the recruitment process is under way and potential candidates have been identified.

Will the staffing for the unit include LPEs (Licensed Psychological Examiners), Psychologists, LCSWs (Licensed Clinical Social Workers), Master's Level Therapist, etc.?

Response: The staffing will include: a program director - RN, a community education manager - marketing, a social worker - licensed MSW, a licensed OT/AT/RT, and a psychiatric tech - clinical aid.

21. Section C. Orderly Development, Item 7

Your response to this item is noted. Please file the most recent complete survey report filed by the Joint Commission.

Response: Please see **Attachment F** for the most recent complete survey report filed by the Joint Commission.

Should you have any questions or require additional information, please do not hesitate to contact me.
As required, a signed affidavit attesting to this information is included in Attachment G.

Sincerely,



Joe Mazzo

Chief Operating Officer

cc: Warren Gooch
Bob Limyansky

Attachment A

1. <u>Name of Facility, Agency, or Institution</u>			
<u>River Park Hospital, LLC</u>			
Name			
<u>1559 Sparta Street</u>			
Street or Route		<u>Warren</u>	
		County	
<u>McMinnville</u>		<u>TN</u>	<u>37110</u>
City	State	Zip Code	
2. <u>Contact Person Available for Responses to Questions</u>			
<u>Joseph Mazzo</u>		<u>Chief Operating Officer</u>	
Name		Title	
<u>River Park Hospital</u>		<u>Joseph.Mazzo@capellahealth.com</u>	
Company Name		email address	
<u>1559 Sparta Street</u>		<u>McMinnville</u>	<u>TN</u> <u>37110</u>
Street or Route		City	State Zip Code
<u></u>		<u>931-815-4203</u>	<u>931-815-4710</u>
Association with Owner		Phone Number	Fax Number
3. <u>Owner of the Facility, Agency or Institution</u>			
<u>Capella Healthcare, Inc</u>		<u>615-764-3000</u>	
Name		Phone Number	
<u>501 Corporate Centre Drive</u>		<u>Williamson</u>	
Street or Route		County	
<u>Franklin</u>	<u>TN</u>	<u>37067</u>	
City	ST	Zip Code	
4. <u>Type of Ownership of Control (Check One)</u>			
A. Sole Proprietorship	<u> </u>	F. Governmental (State of TN or Political Subdivision)	<u> </u>
B. Partnership	<u> </u>	G. Joint Venture	<u> </u>
C. Limited Partnership	<u> </u>	H. Limited Liability Company	<u> X </u>
D. Corporation (For Profit)	<u> </u>	I. Other (Specify) <u> </u>	<u> </u>
E. Corporation (Not-for-Profit)	<u> </u>		

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

Attachment B

13. **Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area. Will this project involve the treatment of TennCare participants? Yes If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or plans to contract.**

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

RESPONSE: River Park Hospital (RPH) participates in the major TennCare MCOs serving patients in the area: Americhoice, Amerigroup, United Healthcare Community Plan and TennCare Select. In total, RPH participates in approximately 71 managed care organizations/behavioral health organizations. Please see **Attachment A,13 (Tab 6)** for a list of managed care contracts in which RPH participates.

Attachment C

ALTERNATE 1

BASED ON EXISTING CHANGES
TO THE EXISTING SITE PLAN
AND EXISTING RECORD
DRAWINGS AND SURVEY
DATA.

Vo-Tech Drive

Stucco Building
POB 1-Story

Hospital 2-Story
Brick Building with Basement

Hospital 3-story
Added Addition - Brick Building

Proposed
10 Bed
Geri Psych

SEE SHEET D-12 FOR
DETAIL OF THIS AREA

MOB 3-Story
Brick building

Sparta Highway US 70s

STATE ROUTE 1

U.S. 70 S

Cadillac Lane

NOTE

The owner/owner's agent, should have
been consulted prior to any changes
being made to the original drawings.
The owner/owner's agent, should have
been consulted prior to any changes
being made to the original drawings.
The owner/owner's agent, should have
been consulted prior to any changes
being made to the original drawings.

NOTE

ALL CONCRETE FINISHES SHALL BE 3/4" REINFORCED
WITH 1/2" DIA. BARS AT 18" ON CENTER.
ALL CONCRETE SHALL BE 4000 PSI.
ALL CONCRETE SHALL BE 4000 PSI.
ALL CONCRETE SHALL BE 4000 PSI.

NOTE

ALL CONCRETE FINISHES SHALL BE 3/4" REINFORCED
WITH 1/2" DIA. BARS AT 18" ON CENTER.
ALL CONCRETE SHALL BE 4000 PSI.
ALL CONCRETE SHALL BE 4000 PSI.
ALL CONCRETE SHALL BE 4000 PSI.

Total Area: 627797 sq ft

Built - 1996

or 14,412 Acres

SITE LAYOUT



T.B.M.
+FE=952.41

COURT YARD

7	CONCRETE PAVEMENT
C-9	(TYPICAL)

Attachment D

FEDERAL MEDICALLY UNDERSERVED AREAS AND MEDICALLY UNDERSERVED POPULATIONS

	MUAs/MUPs	
County	Whole County	Partial County
Coffee	X	
DeKalb	X	
Grundy	X	
Van Buren	X	
Warren	X	
White	X	

Source: U.S. Department of Health and Human Services,
Health Resources and Services Administration, MUA/P by
State and County as published 7/23/2014

FEDERAL MEDICALLY UNDERSERVED AREAS FOR MENTAL HEALTH SERVICES

	MUAs/MUPs	
County	Whole County	Partial County
Coffee	X	
DeKalb	X	
Grundy	X	
Van Buren	X	
Warren	X	
White	X	

Source: U.S. Department of Health and Human Services,
Health Resources and Services Administration, MUA/P by State and
County as published 7/23/2014

Attachment E

PROJECTED DATA CHART

Give us information for the two (2) years following the completion of this proposal. The fiscal year begins in May. Data for proposed new service only.

		2015	2016
A.	Utilization Data (Patient Days)	<u>13,688</u>	<u>14,375</u>
B.	Revenue from Services to Patients		
1.	Inpatient Services	<u>\$94,423,645</u>	<u>\$101,462,461</u>
2.	Outpatient Services	<u>149,275,445</u>	<u>158,231,971</u>
3.	Emergency Services	<u>0</u>	<u>0</u>
4.	Other Operating Revenue (Specify)	<u>153,234</u>	<u>157,065</u>
	Gross Operating Revenue	<u>\$243,852,324</u>	<u>\$259,851,497</u>
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	<u>\$191,144,428</u>	<u>\$204,302,247</u>
2.	Provision for Charity Care	<u>437,091</u>	<u>476,978</u>
3.	Provisions for Bad Debt	<u>8,259,554</u>	<u>8,609,418</u>
	Total Deductions	<u>\$199,841,073</u>	<u>\$213,388,643</u>
	NET OPERATING REVENUE	<u>\$44,011,251</u>	<u>\$46,462,854</u>
D.	Operating Expenses		
1.	Salaries and Wages	<u>\$18,062,234</u>	<u>\$19,677,807</u>
2.	Physician's Salaries and Wages	<u>945,000</u>	<u>945,000</u>
3.	Supplies	<u>6,252,711</u>	<u>6,501,806</u>
4.	Taxes	<u></u>	<u></u>
5.	Depreciation	<u>2,994,786</u>	<u>2,701,807</u>
6.	Rent	<u>518,839</u>	<u>524,839</u>
7.	Interest, other than Capital	<u>3,390,976</u>	<u>3,323,156</u>
8.	Management Fees:		
a.	Fees to Affiliates	<u>617,914</u>	<u>636,451</u>
b.	Fees to Non-Affiliates	<u>0</u>	<u>0</u>
9.	Other Expenses (Specify)		
	Professional Fees	<u>2,906,844</u>	<u>3,006,844</u>
	Purchased Services	<u>4,398,197</u>	<u>4,493,512</u>
	Utilities and Maintenance	<u>2,287,371</u>	<u>2,321,306</u>
	Insurance	<u>573,091</u>	<u>524,839</u>
	Other: Ancillary Expenses	<u>2,671,337</u>	<u>2,827,858</u>
	Total Operating Expenses	<u>\$45,619,300</u>	<u>\$47,485,226</u>
E.	Other Revenue (Expenses) -- Net (Specify)	<u></u>	<u></u>
	NET OPERATING INCOME (LOSS)	<u>(\$1,608,049)</u>	<u>(\$1,022,372)</u>
F.	Capital Expenditures		
1.	Retirement of Principal	<u>\$0</u>	<u>\$0</u>
2.	Interest	<u>0</u>	<u>0</u>
	Total Capital Expenditures	<u>\$0</u>	<u>\$0</u>
	NET OPERATING INCOME (LOSS)	<u>(\$1,608,049)</u>	<u>(\$1,022,372)</u>
	LESS CAPITAL EXPENDITURES	<u>(\$1,608,049)</u>	<u>(\$1,022,372)</u>

Attachment F



SUPPLEMENTAL- # 1

July 24, 2014

3:05pm

January 15, 2014

Joint Commission ID#: 7866
Accreditation Activity: POC-MS
Accreditation Activity Due: 11/29/2013
Program: Hospital Accreditation
Program

Tim McGill
CEO
River Park Hospital
1559 Sparta Road
Mc Minnville, Tennessee 37110

Dear Mr. McGill:

The Joint Commission would like to thank your organization for participating in the Joint Commission's Accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services.

As a result of the recent information submitted for MS.01.01.01 Medical Staff plan of correction, The Joint Commission is pleased to inform you that you now meet the requirement for this standard.

Thank you for your participation and congratulations on your continued compliance with Joint Commission standards.

Sincerely,

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

September 12, 2013

Re: # 7866
CCN: #440151
Program: Hospital
Accreditation Expiration Date: June 01, 2016

Tim McGill
CEO
River Park Hospital
1559 Sparta Road
McMinnville, Tennessee 37110

Dear Mr. McGill:

This letter confirms that your May 29, 2013 - May 31, 2013 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on July 14, 2013 and September 11, 2013, The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of June 01, 2013.

The Joint Commission is also recommending your organization for continued Medicare certification effective June 01, 2013. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following location(s):

Middle Tennessee Surgical Center
145 Health Way, McMinnville, TN, 37110

River Park Hospital
1559 Sparta Road, McMinnville, TN, 37110

We direct your attention to some important Joint Commission policies. First, your Medicare report is publicly accessible as required by the Joint Commission's agreement with the Centers for Medicare and Medicaid Services. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or health care services you provide.



SUPPLEMENTAL- # 1

July 24, 2014

3:05pm

Sincerely,

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

River Park Hospital
1559 Sparta Road
Mc Minnville, TN 37110

Organization Identification Number: 7866

Program(s)
Hospital Accreditation

Survey Date(s)
05/29/2013-05/31/2013

Executive Summary

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission
Summary of Findings

SUPPLEMENTAL- # 1

July 24, 2014

3:05pm

Evidence of **DIRECT** Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	IC.02.02.01	EP2

Evidence of **INDIRECT** Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.02.01	EP5
	LS.02.01.10	EP9
	LS.02.01.20	EP13
	MM.04.01.01	EP1
	MS.01.01.01	EP3,EP21,EP36
	RC.01.01.01	EP19
	RI.01.03.01	EP13
	TS.03.02.01	EP2

The Joint Commission
Summary of CMS Findings

SUPPLEMENTAL- # 1

July 24, 2014

3:05pm

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard
§482.24(c)(4)(v)	A-0466	HAP - RI.01.03.01/EP13	Standard

CoP: §482.25 **Tag:** A-0490 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.25 Condition of Participation: Pharmaceutical Services

The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.

CoP Standard	Tag	Corresponds to	Deficiency
§482.25(b)(5)	A-0507	HAP - MM.04.01.01/EP1	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.10/EP9, LS.02.01.20/EP13	Standard

CoP: §482.51 **Tag:** A-0940 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)	A-0951	HAP - IC.02.02.01/EP2	Standard

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.02.01



Standard Text: The hospital manages risks related to hazardous materials and waste.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

5. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.



Scoring

Category : C
Score : Partial Compliance

Observation(s):

EP 5

Observed in Tracer Visit at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site.

During review of the high level disinfection of transvaginal ultrasound probes in Radiology using OPA Cidex, it was noted that there was no eyewash station available within 10 seconds of travel from the disinfection site. The MSDS sheet for OPA Cidex recommends a 15 minute eyewash in the event of an eye splash with this reagent.

Observed in Tracer Visit at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site.

During review of the high level disinfection of transesophageal echocardiogram scopes using OPA Cidex also being performed in the Radiology department but at a different site, it was noted that there was no eye wash station accessible within 10 seconds of an accidental exposure. The MSDS sheet on OPA Cidex recommends a 15 minute rinse in the event of an eye splash.

Chapter: Infection Prevention and Control
Program: Hospital Accreditation
Standard: IC.02.02.01



Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

2. The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4)



Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.

Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at

http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).

Scoring

Category : A

Score : Insufficient Compliance

Observation(s):

EP 2

§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.

This Standard is NOT MET as evidenced by:

Observed in Tracer Visit at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.

During tracer activities in Radiology where high level disinfection was performed on transvaginal ultrasound probes and Transesophageal echocardiogram scopes, it was noted that the bottle of Cidex OPA test strips had not been dated when opened. The test strips are to be discarded 90 days after opening per manufacturer's recommendations. Additionally, the test strips were not tested when they were opened to assure that they were not defective.

Chapter: Life Safety
Program: Hospital Accreditation
Standard: LS.02.01.10

ESC 60 days

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material.

Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)



Scoring

Category : C

Score : Partial Compliance

Observation(s):

EP 9

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101@2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.

In the 1-hour smoke wall on the third floor by the nursing station there was a 3" EMT conduit sleeve containing cabling that was not completely sealed. There was an approximately 1-inch hole in the intumescent material where cabling had been removed.

Observed in Building Tour at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.

There is a 1/2" EMT conduit which contains a computer cable and is penetrating the 2-hour rated fire wall above the doors to the Rehab unit that is not sealed.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20



Standard Text: The hospital maintains the integrity of the means of egress.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.10.1)



Scoring

Category : C

Score : Partial Compliance

Observation(s):

EP 13

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101@2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.

There was a patient satisfaction computer and one workstation on wheels located in the egress corridor by the 3rd floor nursing station.

Observed in Building Tour at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.

A free-standing hand sanitizer stanchion was located in the egress corridor on the Rehab unit.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.01.01.01

ESC 60 days

Standard Text: Medical staff bylaws address self-governance and accountability to the governing body.

Primary Priority Focus Area: Organizational Structure

Element(s) of Performance:

3. Every requirement set forth in Elements of Performance 12 through 36 is in the medical staff bylaws. These requirements may have associated details, some of which may be extensive; such details may reside in the medical staff bylaws, rules and regulations, or policies. The organized medical staff adopts what constitutes the associated details, where they reside, and whether their adoption can be delegated. Adoption of associated details that reside in medical staff bylaws cannot be delegated. For those Elements of Performance 12 through 36 that require a process, the medical staff bylaws include at a minimum the basic steps, as determined by the organized medical staff and approved by the governing body, required for implementation of the requirement. The organized medical staff submits its proposals to the governing body for action. Proposals become effective only upon governing body approval. (See the 'Leadership' (LD) chapter for requirements regarding the governing body's authority and conflict management processes.)

Note: If an organization is found to be out of compliance with this Element of Performance, the citation will occur at the appropriate Element(s) of Performance 12 through 36.

**Scoring****Category :**

A

Score :

Insufficient Compliance

21. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process, as determined by the organized medical staff and approved by the governing body, for selecting and/or electing and removing the medical executive committee members.

**Scoring****Category :**

A

Score :

Insufficient Compliance



36. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: If departments of the medical staff exist, the qualifications and roles and responsibilities of the department chair, which are defined by the organized medical staff, include the following:

Qualifications:

- Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

Roles and responsibilities:

- Clinically related activities of the department
- Administratively related activities of the department, unless otherwise provided by the hospital
- Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges
- Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department
- Recommending clinical privileges for each member of the department
- Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization
- Integration of the department or service into the primary functions of the organization
- Coordination and integration of interdepartmental and intradepartmental services
- Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services
- Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services
- Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services
- Continuous assessment and improvement of the quality of care, treatment, and services
- Maintenance of quality control programs, as appropriate
- Orientation and continuing education of all persons in the department or service
- Recommending space and other resources needed by the department or service

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: When departments of the medical staff do not exist, the medical staff is responsible for the development of policies and procedures that minimize medication errors. The medical staff may delegate this responsibility to the organized pharmaceutical service.

Scoring

Category :

A

Score :

Insufficient Compliance

Observation(s):

EP 3

Observed in Document Review at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site.
The medical staff bylaws had not been amended to comply with the requirements of elements of performance 21 and 36 outlined below.

EP 21

Observed in Document Review at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site.
During review of the medical staff bylaws, there were provisions for the selection and/or election of members to serve on the Medical Executive Committee, but the bylaws had no provision for the removal of such members if deemed necessary by the medical staff.

EP 36

Observed in Document Review at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site.
Medical staff bylaws provided for the organization of the medical staff into two clinical departments, Medicine and Surgery. The chairs of these departments are also considered medical staff officers. The only qualifications stipulated in the bylaws for these department chairs are that these individuals maintain membership in the active medical staff in good standing. There was no requirement stipulated in the bylaws for certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

Chapter:	Medication Management
Program:	Hospital Accreditation
Standard:	MM.04.01.01
Standard Text:	Medication orders are clear and accurate.
Primary Priority Focus Area:	Medication Management



Element(s) of Performance:

1. The hospital has a written policy that identifies the specific types of medication orders that it deems acceptable for use.

Note: There are several different types of medication orders.

Medication orders commonly used include the following:

- As needed (PRN) orders: orders acted on based on the occurrence of a specific indication or symptom
- Standing orders: A pre-written medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances
- Automatic stop orders: Orders that include a date or time to discontinue a medication
- Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient's status
- Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval
- Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status
- Orders for compounded drugs or drug mixtures not commercially available
- Orders for medication-related devices (for example, nebulizers, catheters)
- Orders for investigational medications
- Orders for herbal products
- Orders for medications at discharge or transfer



Scoring

Category :

A

Score :

Insufficient Compliance

Observation(s):

EP 1

§482.25(b)(5) - (A-0507) - (5) Drugs and biologicals not specifically prescribed as to time or number of doses must automatically be stopped after a reasonable time that is predetermined by the medical staff.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.

During a patient tracer, it was noted that titrating orders were written in the ICU. There was not a policy that addressed titrating orders as required.

Chapter:

Record of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

RC.01.01.01

ESC 60 days

Standard Text:

The hospital maintains complete and accurate medical records for each individual patient.

Primary Priority Focus Area:

Information Management

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.



Scoring

Category : C

Score : Insufficient Compliance

Observation(s):

EP 19

§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.

During a patient tracer it was noted that an admission order in the OB unit was not timed by the provider as required by hospital policy.

Observed in Individual Tracer at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.

During a patient tracer, it was noted that the admission order written by the physician was not timed as required by policy.

Observed in Individual Tracer at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.

During a patient tracer, it was noted that a History and Physical completed by the physician was not signed dated or timed as required by hospital policy.

Observed in Record Review at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.

During a record review, it was noted that a patient consent dated on 5/12/13 was not dated or timed as required by hospital policy.

Chapter: Rights and Responsibilities of the Individual

Program: Hospital Accreditation

Standard: RI.01.03.01

ESC 60 days

Standard Text: The hospital honors the patient's right to give or withhold informed consent.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

13. Informed consent is obtained in accordance with the hospital's policy and processes and, except in emergencies, prior to surgery. (See also RC.02.01.01, EP 4)



Scoring

Category : C

Score : Partial Compliance

Observation(s):

EP 13

§482.24(c)(4)(v) - (A-0466) - [All records must document the following, as appropriate:]

(v) Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.

This Standard is NOT MET as evidenced by:

Observed in Record Review at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.

During a record review, it was noted that consent for blood products was not witnessed by staff or the physician as required by hospital policy.

Observed in Record Review at River Park Hospital (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.

During a record review, it was noted that consent for blood products was not witnessed by staff or the physician as required by hospital policy.

Chapter: Transplant Safety

Program: Hospital Accreditation

Standard: TS.03.02.01



Standard Text: The hospital traces all tissues bi-directionally.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

2. The hospital identifies, in writing, the materials and related instructions used to prepare or process tissues.



Scoring

Category : C

Score : Insufficient Compliance

Observation(s):

EP 2

Observed in Record Review at Middle Tennessee Surgical Center (145 Health Way, Mc Minnville, TN) site.

During closed chart review of a patient who underwent an ACL repair with implantation of a tibialis tendon graft, the tendon graft was reconstituted with normal saline but the manufacturer, lot number and expiration date of the saline solution were not documented.

Observed in Record Review at Middle Tennessee Surgical Center (145 Health Way, Mc Minnville, TN) site.

During closed chart review of a second patient who underwent an ACL repair with implantation of a tibialis tendon graft, the tendon graft was reconstituted with normal saline but the manufacturer, lot number and expiration date of the saline solution were not documented.

Observed in Record Review at Middle Tennessee Surgical Center (145 Health Way, Mc Minnville, TN) site.

During closed chart review of a third patient who underwent an ACL repair with implantation of a tibialis tendon graft, the tendon graft was reconstituted with normal saline but the manufacturer, lot number and expiration date of the saline solution were not documented.

Attachment G

